THE CANADIAN NURSE

L'Infirmière canadienne

VOLUME 55 **NUMBER 1**

JANUARY 1959

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Editor and Business Manager
MARGARET E. KERR, M.A., R.N.

Assistant Editor
JEAN E. MacGREGOR, B.N., R.N.

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Between Ourselves

Watchwords have had a long and interesting history of use in military circles where they served as the secret or code words to identify friends. Without the correct password no person could gain admittance to the ancient beleaguered castle, the military encampment or, even today, to any closely guarded zone.

In modern times a new meaning has been ascribed to watchword. It is now interpreted as a phrase or a single word that expresses belief in the principles of an organization. In the nursing world, the watchword given to the International Council of Nurses by the out-going president, Mlle Marie M. Bihet in 1957 was *Wisdom*.

Last June our new national president, Miss **Alice Girard**, in her initial address gave the nurses of Canada a watchword for this biennium — *Faith*. To attempt an adequate definition of what is meant by that word is not an easy task. The dictionary gives half a dozen different interpretations each of which, again, would require a careful analysis — trust and confidence in another; fidelity, loyalty; honesty. Which did our president mean?

Following the tradition of a great many years Miss Girard, as guest editor, has given us a very sound understanding of the meaning of faith. Let us respond to her lead in our devotion to every aspect of our professional work.

* * *

Commonly called "crossed eyes" or a "lazy eye," strabismus is usually due to the fact that the eyes are not seeing objects clearly when used together. To overcome this difficulty one eye is unconsciously turned away from the object that is being viewed. This squint may be due simply to a need for glasses. When a properly fitting pair is worn regularly the squint may be improved or entirely corrected.

Since strabismus usually becomes apparent in childhood, especially following an illness, every nurse has an obligation to be observant, to be familiar with the care that should be given and to advise parents on the proper course to follow. **Dr. Howard Reed** supplies the information that nurses require to be cognizant of their important role.

* * *

A continuing problem in every school of nursing, large or small, is to organize the student rotation in such a manner that every student will receive her full share of experience in every department without being side-tracked to fill gaps in the service needs of the hospital. Sometimes the director of nursing herself undertakes the task of arranging the rotation schedule; sometimes it is developed by the chief instructor. It may be a thoughtfully constructed pattern or it may even be a rather hit-and-miss affair.

Miss **Margaret Street** describes in careful detail a master plan of rotation, which if followed closely would assist any nurse responsible for the rotation of students to accomplish her task with a degree of competence that would increase with each new class.

* * *

The Ontario Department of Health has estimated that some 800 of all the babies born in that province each year will be suffering from hemolytic disease of the newborn. Though there is no known means of preventing the occurrence of this condition, the studies that laboratories can make by examining the pregnant woman's blood will enable them to predict whether the infant will or will not have erythroblastosis. With this knowledge, adequate early treatment can be instituted that will ensure survival and normal development for nearly 100 per cent of the affected infants.

A survey undertaken two years ago revealed that there were many areas in Ontario with insufficient laboratory facilities for the investigation of this disease and with no personnel trained in the technique of its treatment. Happily, this situation has been corrected. Centres for investigation and treatment are now established throughout the province, so that all physicians now have these services available for their patients. Every Ontario mother, no matter where she lives, by consulting her doctor early in her pregnancy is assured of all that modern medicine can provide in the management of this disease.

The ant finds kingdoms in a foot of ground. — Stephen Vincent Benet

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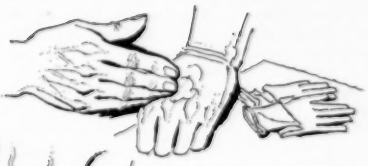

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Edited by **DEAN F. N. HUGHES**

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Administration—Adult dosage: One tablet every 3 or 4 hours.

Children: According to age.

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Description—Tablets: Aluminum hydroxide gel dried 10 gr, magnesium hydroxide 5 gr. liquid, aluminum hydroxide gel U.S.P. XIII 1 fl. oz., magnesium hydroxide 13 gr.

Indications—As a gastric antacid and adsorbent without tendency to constipate. Buffering effect continues over 2 hours.

Administration—One dessertspoonful of liquid or 1 tablet 3 times daily after meals. Frequency may be increased in peptic ulcer to every 2 to 4 hours.

CARBAMIDE

Description—Carbamide (urea) powder.

Indications—As a diuretic in cardiac edema, incontinence of urine in children, externally to stimulate granulation tissue.

Administration—¼ to ½ teaspoonful in ½ glass of water once or twice a day. A 2% solution for external application.

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Description—Each scored tablet contains 15 mg. of erythrol tetranitrate.

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Precautions—Caution should be observed in patients with cerebral hemorrhage or glaucoma. Even though the administration of Cardilate tablets permits more normal activity, patients should not be allowed to interpret freedom from attacks as a signal to drop all restrictions.

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The ancient tend to ignore the fact that the years do not grow old as men grow old, but gather momentum as they multiply, bringing with them new problems and new demands to press upon heart and mind. Age is not a synonym of wisdom; experience is not a substitute for freshness of mind. The past can be useful but only to the extent that its lessons may help to prevent miscalculation, and contribute to the needs of the present. History, which after all, is only human experience, is a warning and a guide. It is not a precept. — G. HERBERT LASH

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L'Infirmière canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 55 NUMBER 1

MONTREAL, JANUARY 1959

The Meaning of Faith

AT OUR GENERAL MEETING in June, 1958 it was my privilege to choose the watchword for this biennium and spontaneously I chose the word Faith. Now, as I try to analyze why I made this choice, I find the task rather difficult since faith is a composite of so many elements and the relevant importance of each one is difficult to assess.

Was it belief in the great truths preserved for us and which form part of our heritage? Was it reliance on the intrinsic nature of ourselves? Could it have been trust in our ability to meet the new, the strange, the challenging situations which we encounter each day? Was it, perhaps, confidence derived from the many accomplishments which have been linked together like the rings of a chain that was started away back in 1908?

It could have been all of these — belief, trust and confidence — because each one is a part of what I saw in the meaning of Faith. Yes, we can have faith in our heritage, we of Canada, because ours is a country vast, varied and vital and in which there is so much space to grow. Our people, like our land, is varied and blessed with a multi-patterned cultural heritage, with two main streams, French and English in origin, flowing side by side down through the centuries. This is a rich past from which our own Canadian culture has been nourished. Though

(G. Carpenter)

ALICE GIRARD

differences between these two streams at times have seemed sharp, their likenesses were greater than their differences as both bore the essential qualities of western European culture, making harmonious sharing between the two possible.

As nurses, we have an old and growing heritage. Early, some of our women found a way to serve God and their fellowmen by caring for the sick and injured. The memory of devoted women like Jeanne Mance, working to relieve the suffering of the cruelly hurt and dying, inspires each of us as we seek to nurse the ill and promote the health of the individual. Today, Canadian nurses continue to build that heritage for the nurses of the future as both national groups hold in reverence the names of the admirable women who have inspired us in raising the standards of nursing care given to a rapidly expanding population and improving the professional education of nurses and the health education of all Canadians. Our nurses are making a special contribution to nursing all over the world as they join with nurses of other countries to formulate and carry out the programs of international health organizations, and as our schools open their doors to students from countries where nursing education is not yet well developed. Our nursing heritage is both roots to nourish us and a torch to light the way.

Though the past gives us values and ways of behaving that we can trust because they have been tested through time and found to be good through human experience, it is with the complex and often confusing situations of the present that we must cope. It is here truly, in this diversity of today's problems, that faith is most needed and hardest to come by. No small part of our difficulty in living with faith in the present arises from the fact that answers that have come down to us are no longer wholly satisfactory to answer the questions that arise today. Though many of us have been born and reared in homogeneous communities where our parents and our schools told us not only what to do but quite frequently how to do it, very few of us reach maturity without living in heterogeneous communities where new acquaintances and friends do not conform entirely to our pattern of living. Quite often the problems that confront us today are not to be solved by the solutions provided to any of us in our childhood. We are in a changing situation that calls for imaginative and creative living. From our past heritage we can bring only some of the values, some of the principles, and very few of the prescriptions of procedure. The rest we must acquire. This will be possible only if there is communication and understanding between peoples; a willingness to accept the differences of others and to recognize that their beliefs and ways of behaving have validity for them. We in Canada understand this for we have lived with heterogeneity of culture throughout our history. Professionally, we have also lived with diverse disciplines. With greater specialization and the utilization of more kinds of workers to do the job, increasingly we shall need faith in other people whose ways seem new and strange. We are utilizing teamwork and new techniques to speed up communication and understanding in nursing. Interesting examples of new approaches to old problems are being tried every day. One such example was brought to my attention recently when problems between internes and nurses in an emergency department were worked out in one hospital through the means of a closed television circuit with cameras trained in the emergency room and with receiving screens in conference rooms. Needless, to say, this was successful only because skilled persons in the field of social dynamics and human relations helped all those involved to understand what they saw and to seek solutions to the solvable aspects of the problems. The nurses and the internes, alike, found new potentials in their work and more satisfaction in the interpersonal relations with their coworkers. They took on some new values; but they also had to rid themselves of useless tradition to which they had frantically clung.

One area of diversity that may be expected to arise with the demands for more and varied personnel to meet the nursing needs of Canadians is the kinds of nursing schools. We are in the midst of an evaluation study and we hope to go into an accreditation

program for which we are trying to prepare nationally. These plans leave way for diversity and provide for the flexibility that will permit experimental programs aimed at meeting the rising needs. Agencies that employ nurses from the varying kinds of schools will also have to understand what each kind of worker has been prepared to do. Staff nurses as well as supervisors will need to understand the differences in the preparation of the various kinds of nursing personnel if the total nursing service is to be cooperatively coordinated and the needs of the patients adequately and efficiently met.

Another challenging situation in nursing is that which is being brought about through government hospital insurance. Here, also, our capacity to accept and adapt efficiently to new situation fraught with critical elements of change is being severely taxed. Many of us have already successfully tackled this problem and are ready to pass on to others the experience gained through this change.

So in our complex diversified world, faith means having confidence in ourselves and in our ability to adapt to changing situations. It is also being able to have confidence in other people, to share their experiences and to trust in their willingness to help. It also means understanding of and respect for others.

It is only a small step to believe in the future, when one has faith in what is being done today. If we can adapt to meet the changing situation of the immediate moment, we can adapt to meet the future. Adapting in this case often means to unlearn the old and to learn the new. To unlearn may be painful because what we have learned is often precious to us; because of the effort expended in the learning, because of the force of tradition and because of the satisfactions that we have had when we successfully used that knowledge in the past. But when knowledge is no longer satisfactory, nor relevant, perhaps even dangerous, we must discard it and expend the energy needed to seek other ways.

Nurses, reared in tradition, have often found this difficult. Every nurse knows how difficult it is to help a patient build self-confidence and independence by working out his own solutions for his problems or letting him make the necessary efforts to become self-sufficient when she feels that she could do all this for him far more expertly and derive much satisfaction out of doing it. However when these same nurses gain insight into the deleterious effects of their traditional methods they know they must effect a change of attitude and of goals in their work.

Many nurse educators have yet to unlearn patterns of training and methods of teaching that prepared students solely for palliative and curative nursing. They must learn ways to prepare these future professional nurses for essential health promotion, illness and accident prevention, and rehabilitative functions. Moreover, we all have much to learn about motivating a desire in both students and ourselves to seek out new truths through study and research and to apply them in the practice of nursing. Experimental programs in nursing schools in Canada will provide some of the knowledge needed to improve nursing education, but the instructors will know that having the data is but the first step in the difficult art of producing a competent and efficient nurse with a mature mind and a heart that still responds to the right stimuli. They as teachers must continuously search for better and more progressive methods of improving the education of students and therefore the nursing services to the sick.

So it would seem that the watchword "Faith" might well mean all these things: belief in those truths that form part of our heritage and that, held up against the bright light of today's reality, are found to be still valid; reliance on ourselves, personally and professionally, secure in our own individuality among diversity all about us; confidence in our adaptability to meet the new, facing its reality, imaginatively calling into play relevant knowledge; and courageously expending the energy and emotion to discard what is no longer beneficial. Above all we must have faith in our mission which still remains the same in spite of the changing world in which we live.

ALICE GIRARD, President
Canadian Nurses' Association

Squint or Strabismus

HOWARD REED, M.B., M.S., (LOND.), F.R.C.S. (ENG. & C.), F.A.C.S.

SQUINT IS BY FAR the most important problem in ophthalmology because about 3 per cent of all children suffer from this condition. Without treatment about one half of these become practically blind in one eye. All nurses should therefore have some knowledge of strabismus.

DEFINITION

A squint is any condition in which both eyes are not directed at the same object. A more exact but somewhat technical definition is that strabismus is any condition in which the visual axes are not parallel.

A mother will often consult a doctor because she thinks that her child is squinting. By this she means that he is half closing his eyelids. This is due to intolerance of bright light. It is true that many children with strabismus will close the deviating eye in a strong light. But this symptom does not always mean that strabismus is present.

HISTORY

The "evil eye" of folklore and mythology undoubtedly referred to the condition of squint. The ancients did not understand that this was a physical deformity. They attempted to explain it as a visitation of the gods. It was a condition which had an unpleasant appearance and it was often thought that people with it possessed evil or demoniac powers.

As long ago as 400 B.C. Hippocrates wrote about it and recognized that it occurred in families. Throughout the centuries no real advance was made in the understanding or treatment of the condition until relatively recent times. A wandering quack, Chevalier Taylor, mentioned it in his writings and stated that he treated a convergent squint by dividing the medial rectus muscle. In 1896, Javal, a French ophthalmic surgeon, was the first to write a book upon the subject and lay down the principles which still form the basis of modern treatment.

Dr. Reed is chief of the Department of Ophthalmology of the Winnipeg Clinic, Winnipeg, Man.

CAUSE

1. *Sex* — Squints occur equally in both sexes.

2. *Heredity* — There is a family history of strabismus in about 50 per cent of cases.

3. *Refractive errors* — A high proportion of patients with the condition have high refractive errors, particularly hypermetropia and astigmatism.

4. *Trauma* — This may occur at birth or as the result of an accident.

(a) *Birth*: There is no doubt that a few cases of squint occur as a result of injury during birth. It is possible that excessive moulding of the head may give rise to sixth nerve palsy and weakness of the lateral rectus muscle, thus causing a convergent squint. On occasion the application of forceps in a difficult delivery may injure one of the nerves or extraocular muscles and so cause a squint.

(b) *Accident*: In adults, head injuries not infrequently damage nerves supplying the extraocular muscles and thus produce paralytic squints.

5. *Cerebral tumor* — An intracranial tumor, particularly in the posterior cranial fossa, may give rise to raised intracranial pressure. This in turn damages the sixth nerve, causes weakness of the lateral recti, and leads to a convergent squint. These patients usually have headache and vomiting. Although such cases are not common all patients with squint should be examined at its onset to exclude the possibility of a tumor.

6. *Infectious disease* — There is no question that a squint may first become apparent after an infectious disease such as measles, mumps, whooping cough or scarlet fever. Inquiry will often reveal the fact that a relative has a squint and examination will show that the child has a high refractive error. In this case, the infectious dis-

ease has merely weakened the child's resistance so that the squint has appeared. It might be said that the infectious disease was the trigger that fired the gun that was loaded by the refractive error and the hereditary tendency.

Types of Squint

Esotropia or Convergent Squint: The convergent squint is by far the most common form and occurs in about 70 per cent of cases.

Right esotropia or convergent squint

Exotropia or Divergent Squint: This is a less common form of squint and occurs in about 30 per cent of patients.

Hypertropia or Vertical Squint: In most of these cases a horizontal defect is associated with the vertical defect.

All three of these squints may be further classified into three groups. They may be:

1. *Intermittent* — in which the eye deviates only occasionally and appears to wander when the child is tired or daydreaming.

2. *Constant* — in which one eye turns constantly in, out, or up. It is this eye which tends to develop amblyopia.

3. *Alternating* — this means that each eye may be used in turn and the vision in each eye is normal. In alternating convergent squints the right eye is used when looking to the left and the left eye is used when looking to the right.

Development of Vision

The vision of infants is poor. It is probably 20/120 or less. Not until the age of six does vision improve to 20/20. But the eye must be used for this development to occur. In a constant convergent squint, the convergent eye is never used and its vision does not develop. In fact, is seems that an active suppression takes place so that the vision in the eye actually deteriorates. If the eye is not used for some time, it

Right extropia or divergent squint

may become practically blind and incapable of seeing more than movements.

Treatment

1. *Immediate*: Only too often a child of about the age of nine or ten is brought into a doctor's office with a squint which has been present for many years. When the parents are asked why they have delayed bringing the child for treatment, they reply that they were told that nothing could be done until the child was older, or to wait until he was older because time might cure it. These fallacies are still propagated not only over the garden fence but also in more enlightened

Left hypertropia or vertical squint

circles where the gravity of this condition should be better understood.

It is essential that treatment should be undertaken as soon as a squint develops. If the child is very young it may not be possible to try to rectify the squint at once, but an examination should be made to exclude diseases of the retina, optic nerve, or lens which might be responsible for the squint.

Treatment may be initiated in a child as young as ten months. Delay means that amblyopia will develop in a constant squint. If this is allowed to persist after the age of six the child is likely to be blind in the unused eye for the rest of its life. This is a serious matter. If the good eye should be accidentally damaged then the patient is fit only for a blind register. All who have

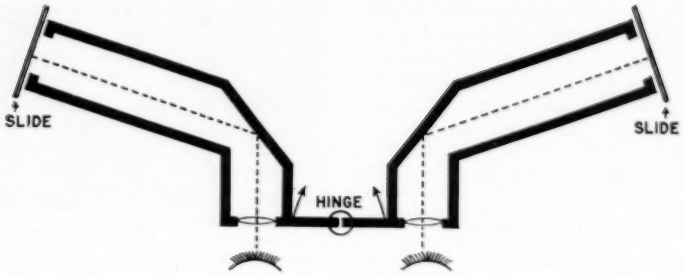

Figure 1

had the unhappy experience of registering such a patient as blind, appreciate the importance of treating the child with a squint before the age of six when there is hope of restoring vision in the squinting eye.

2. *Cycloplegia*: It is important to use atropine or a similar drug to dilate the pupil. The retina must always be examined to exclude intraocular inflammation, a congenital cataract or an abnormality of the optic nerve which may be responsible for defective sight and the development of a squint. When a child has a congenital anomaly of the squinting eye it may be impossible to improve the sight. In this case treatment must be modified.

3. *Refraction*: If a child requires glasses in order to see clearly they must be provided. In about 20 per cent of patients with a convergent squint the wearing of glasses for hypermetropia will result is a permanent cure of the deviation.

4. *Patching*: If the child has a constant squint and the vision of the squinting eye is defective, it is essential to patch the good eye to compel the child to use the lazy eye. An adhesive patch, put over this eye, is worn all day, every day, until the vision of the squinting eye is equal to that of the good eye. It is sometimes necessary to patch a fixing eye in this way for three or four months. The child should be seen at frequent intervals in order to check the improvement in vision. It is a great encouragement to the mother and to an intelligent child to realize that a few weeks of patching has resulted in the improvement of vision by one or more lines of type. It is often a good plan to advise the parents to allow the child to watch T.V. or go to the movies with the eye patched. The constant movement on the screen and the child's interest in the program are perhaps the best stimuli to a lazy eye that can be devised.

5. *Orthoptics*: This valuable branch of ophthalmology has developed in the last quarter of a century although Javal enunciated the principles in 1896. Orthoptics deals with diagnosis of the state of the binocular vision and its training. Binocular vision is classified into three grades, and it is measured by means of an amblyoscope or similar instrument. Each eye looks down a separate tube at the end of which is placed an illuminated slide. (Fig. 1)

Grade I. This is the ability to see dissimilar objects with each eye and to be aware of both at the same time. Slides commonly used to diagnose grade I binocular vision are those in which one eye sees a parrot and the other eye a cage.

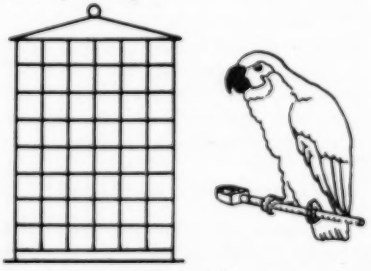

Figure 2

Fig. 2. The child is asked to swing the tubes and put the parrot in the cage. If he can do so without either the parrot or the cage disappearing, grade I vision is present.

Grade II. This is the ability to fuse similar images. Pictures used in this

case are a rabbit without a tail before one eye whilst the other eye sees a rabbit without the bouquet of flowers.

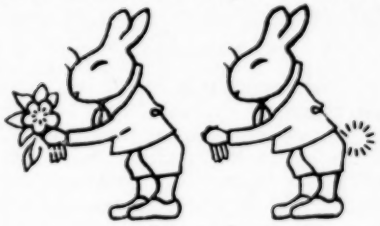

Figure 3

Fig. 3. The patient with grade II vision will see a complete rabbit holding the bouquet. The absence of any part of the image will indicate the lack of grade II vision and will show which eye is being used.

Grade III. This indicates stereoscopic vision or the perception of depth and is the highest grade of binocular vision. No squint can be accounted completely cured unless grade III binocular vision is obtained.

When the eyes have been made straight or nearly so by operation and the visual acuity is equal in each eye, orthoptic training is desirable to develop full binocular vision and normal ocular movements. Regular reviews at intervals are essential lest a relapse occur and further operations be required. All children with any tendency to squint should be kept under constant supervision up to the age of eight. If grade II or grade III binocular vision is obtained, relapse rarely occurs.

6. *Operation.* If the wearing of glasses, patching, and orthoptics, fail to correct the angle of deviation, an operation must be performed. It is important to warn parents that one cannot guarantee a perfect result in one operation. It is sometimes necessary to perform two or even three operations to straighten the eyes. It is unwise to attempt to correct a large deviation in one surgical procedure, because this may result in an over-correction. For example, a converging eye may be made to diverge. Such an over-correction may be difficult to put right.

Each eye has six muscles and all collaborate in each ocular movement. When the eye is looking in any given direction, only one muscle may be acting maximally but the other muscles are also in a state of tone, guiding and controlling the position of the eye to prevent it swaying off the desired direction.

Parents are often afraid that an operation may damage the sight of the eye. Only the muscles are operated on during a squint operation so there is no danger of this happening.

There are two principles involved in all squint surgery:

1. Overacting muscles are weakened.

or

2. Weak muscles are strenghtened.

Overacting muscles are weakened by dividing their attachment to the eyeball and sewing the muscle to the eyeball a little further back. This lengthens the muscle so that it is relatively weaker. Muscles are strengthened by cutting a small portion out of the muscle close to its attachment to the eyeball and resuturing the cut end of the muscle back to its previous attachment. This shortens the muscle by 5 or 6 millimetres and thereby increases its power of action.

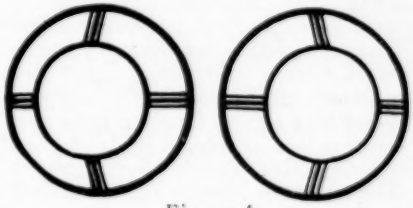

Figure 4

Fig. 4. If the eyes are capable of stereoscopic vision these two slides give the impression of looking into a bucket.

Nursing

A generation ago children were kept in hospital for ten days following surgery, in many cases with both eyes bandaged. Since then the post-operative time in hospital has been decreasing. At present, most surgeons keep children in hospital for no longer than two or three days.

No special preoperative care is required but the usual preanesthetic precautions are taken. When the child is anesthetized, the eyelashes are cut to half length. This is done to prevent them being cut during the operation and

falling into the wound. The scissors should be well greased so that the cut lashes stick to the grease and do not fall into the conjunctival sac. The face is cleaned with Zephiran and painted with the antiseptic of the surgeon's choice.

The postoperative nursing is simple. Only the operated eye is covered with a pad and elastoplast. As soon as the child has recovered from the anesthetic he is allowed to get up and play about the ward. He may even watch T.V. if it is available. Few children attempt to remove the dressing and there is little or no danger of damage to the eye itself. Children do not rub the eye because it causes pain.

The eye is uncovered one or two days after operation. Dark glasses may be worn for a few days if bright light bothers the child. An antibiotic ointment is instilled thrice daily for a few days. The conjunctiva is usually stitched with fine catgut sutures which are absorbed or sloughed out in about a week. The eye is irritable until this happens, but as soon as the catgut has absorbed irritation practically ceases. The eye often remains red for several weeks or even months and parents must be warned of this to prevent anxiety.

Surgery does not affect the vision of the eye. Thus, if glasses were needed before operation they must be worn after it.

Prognosis

What results may one expect from the treatment of strabismus?

A complete cure has been achieved if the child has straight eyes, normal sight in each eye, and binocular vision. The latter means that the two eyes are working together and the child has stereopsis. If seen early nearly 50 per cent of children are cured.

If there is delay in treatment the visual results are likely to be less successful. In all cases, however, the two eyes may be made to appear straight by operation so that a casual observer cannot tell that a squint has ever been present.

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In the Good Old Days

(The Canadian Nurse — January, 1919)

The field of Public Health Nurses gets wider every year; or perhaps it would be better to say the opportunities of that field are getting clearer to our eyes, and the call for nurses is great all over the country.

* * *

The Quebec Provincial Nurses' Association accepted with regret the resignation of the president, Miss Grace Fairley, who has accepted the position of superintendent of the General Hospital in Hamilton.

* * *

Instead of using gauze or cotton as a drain in the dressing of wounds, thin strips of blotting paper may be inserted; for an external dressing, the blotting paper is first crumpled up in the hand. It makes a light, airy, inexpensive dressing, is easily removed, and is more readily destroyed than a cotton dressing.

* * *

It is stated that Cromwell died of influenza. This Italian name for the disease was first used in England during the epidemic of 1743. The first great epidemic of the disease in United States was in 1647, the most recent in 1890.

* * *

To cure hoarseness: Bake a lemon for twenty minutes in a moderate oven. Open one end and dig out the inside, then sweeten it with molasses. Repeat this in one hour. After one eats this the throat will be cleared as if by magic.

To know is nothing at all; to imagine is everything. — Anatole France

Entraide Au-Delà de la Frontière

Traitement de l'Insuffisance Aortique à l'aide d'une Valve en Plastique

Helen Creighton, A.M., J.D.; Charles A. Hufnagel, M.D.
Juanita Thorn, M.S.W. *and* Florence G. Presley, B.S., P.T.

Durant l'automne 1957, notre nation avait le plaisir d'accueillir, en même temps que nos voisins canadiens, la très gracieuse reine Elizabeth d'Angleterre. D'intérêt un peu plus particulier pour celles d'entre nous qui sommes infirmières, est le fait que l'Association des Infirmières canadiennes est sous le patronnage de Sa Majesté.

Toutefois, si en effet nos deux pays participent quelquefois aux mêmes événements sociaux et ont souvent les mêmes problèmes, il est d'un intérêt encore plus frappant qu'un citoyen de la classe moyenne puisse bénéficier de cette participation dans un tout autre domaine. L'histoire de Jacques, un canadien-français de dix-huit ans, qui s'est rendu jusqu'à l'hôpital Georgetown pour le traitement d'une insuffisance aortique, démontre bien comment nous avons joint nos efforts aux vôtres pour traiter adéquatement le cas d'un individu en particulier. Ce récit tiendra compte du patient du point de vue émotif et social, ainsi que de l'aspect médical et chirurgical.

Insuffisance Aortique

Par insuffisance aortique on signifie que d'elle-même la valve de l'aorte est incapable d'empêcher le retour du sang dans le ventricule gauche. La quantité de sang qui ainsi régurgite varie selon le degré d'impuissance de la valve. Les symptômes d'épuisement qui tôt ou tard apparaissent, selon la gravité de la défectuosité mécanique, révèlent une surcharge excessive s'accroissant continuellement et causant ainsi un effort exagéré au myocarde. Toutefois, la modification d'une telle valve, en majeure partie ou complètement, offre à ces patients ainsi incommodés, l'espoir et la perspective d'une vie plus normale.

On trouve dans un cas d'insuffisance aortique les signes suivants:

a. un pouls bondissant;

b. un souffle diastolique entendu au bord sternal gauche;

c. un bruit claqué entendu en regard des gros vaisseaux de l'aine;

d. un souffle de "va et vient" si l'on déprime une artère au doigt;

e. dans les cas avancés, un gros ventricule gauche décelable à la fluoroscopie.

Ces patients ont une haute pression artérielle systolique et une pression diastolique anormalement basse. L'infirmière doit se souvenir qu'afin d'obtenir une pression diastolique adé-

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Helen Creighton (A.M., Université du Michigan; J. D., Université George Washington; B.S.N., Université Georgetown) est professeur adjoint à l'école des infirmières de l'Université Georgetown. Elle enseigne aux infirmières les soins médicaux et chirurgicaux; elle est aussi chargée de la surveillance des étudiantes infirmières, ainsi que de cours à ces dernières à l'hôpital de l'université sur les maladies de la poitrine.

Dr. Charles A. Hufnagel est professeur en chirurgie, professeur en recherches chirurgicales, et directeur du laboratoire expérimental au Centre Médical de l'Université Georgetown. Il est bien connu pour ses recherches en chirurgie du coeur et il est le chef de l'équipe qui a mis au point la valve de plastique dont il est fait mention dans cet article.

Juanita Thorn (M.S.W., Université de Chicago) est directrice de la section s'occupant de l'étude des causes soumises (casework), Département du Service Social, à l'hôpital de l'Université Georgetown.

Florence G. Presley (B.S., Collège Arnold P.T., Université Columbia) est à la tête de la section de Physiothérapie, Département de Médicine Physique et Réhabilitation, à l'hôpital de l'Université Georgetown.

quate, elle doit enregistrer le changement dans le son ainsi que sa disparition. Par exemple, si chez un tel patient le premier son est entendu à 150 et le premier changement apparait à 30 et que le son descend graduellement jusqu'à zéro, la pression artérielle du patient devra être enregistrée comme étant 150/30/0. De plus, on remarque que ces patients ont une pression systolique beaucoup plus haute dans les artères fémorales que dans les brachiales.

Les causes principales de ces dommages causés au coeur sont le rhumatisme articulaire aigu, l'endocardite et la syphilis. Parmi les nombreux groupes de patients qui ont été, à une époque ou une autre, sous observation dans notre centre médical, nous avons constaté que relativement, la plus grande majorité (à peu près 80 pour cent) des patients souffrant purement d'insuffisance aortique, ont à l'origine souffert de rhumatisme articulaire aigu.[1]

Prothèse Valvulaire de Plastique

La prothèse d'une simple valve de plastique ayant la forme d'une balle selon l'adaptation de l'un des auteurs (Dr. Hufnagel) est, de nos jours, la méthode la plus efficace de corriger une insuffisance aortique. Cette valve est moulée tout d'une pièce sans couture et doit être extrêmement lisse et unie. Une telle valve de plastique est munie d'une soupape d'admission, d'un compartiment contenant la balle et d'une voie d'écoulement. Le compartiment est fabriqué de façon à permettre à la balle de se mouvoir en droite ligne du point où elle repose jusqu'aux points d'arrêt de la valve. Une différence de pression du mercure de 5 mm. produit soit l'ouverture ou la fermeture complète de la valve. Sur la surface extérieure à chaque extrémité de la valve il y a une rainure. L'aorte est maintenue en place à différents endroits sur ces rainures à l'aide d'anneaux. La valve est insérée dans l'arche descendante de l'aorte corrigeant ainsi la majeure partie de la régurgitation, sans danger grave pour le patient.

L'insertion de la prothèse valvulaire de plastique dans l'arche descendante de l'aorte, a pour effet de contrôler approximativement soixante-quinze pour cent de reflux. Le coeur se trouve ainsi débarrassé d'une tension excessive. Les rayons-X démontrent que le coeur diminue en dimension. Le rendement du coeur s'améliore, la pression diastolique sous la valve devient normale et toute douleur disparait.

Le Patient et sa Famille

Par un bel après-midi de septembre, Jacques, un jeune canadien-français de dix-huit ans, arrive à Washington, D. C. Souffrant d'une insuffisance de l'aorte à la suite d'une maladie de coeur dont il fut victime vers l'âge de huit ans, son médecin de famille l'a d'abord dirigé vers un médecin de Montréal et de là, vers notre centre médical à l'hôpital Georgetown pour un traitement approprié. Le traitement de l'insuffisance aortique par l'insertion d'une prothèse valvulaire de plastique est bien connu à Montréal, nul doute grâce à plusieurs années d'étroite collaboration dans la chirurgie du coeur d'un des auteurs (Dr. Hufnagel) avec un autre Canadien, feu le docteur Pierre J. Rabil autrefois de Montréal et plus tard professeur adjoint de chirurgie à Georgetown.

Jacques arrive donc dépourvu de toute référence médicale adéquate et même bien entendu d'un dossier personnel. Tout de même, l'expérience qu'a vécue le jeune Jacques démontre jusqu'à un certain point comment en face d'un problème de santé sérieux et menaçant, en dépit de tout ce qui a été écrit au sujet du traitement complet d'un tel cas, certains facteurs humains du patient peuvent être négligés.

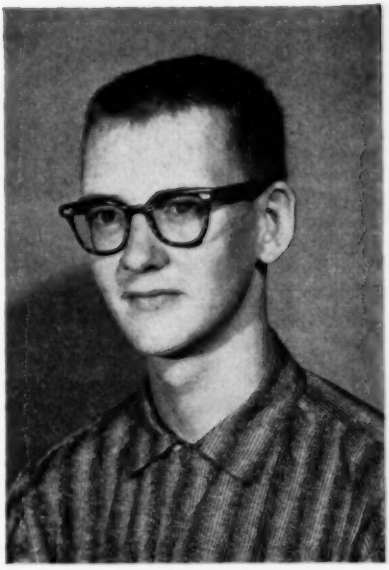
Ainsi, tous sont légèrement étonnés lors de l'arrivée de Jacques à notre centre médical. Si, en réalité, continuellement nous recevons des patients venant de centres assez éloignés de notre propre pays ainsi que de l'étranger, c'est bien la première fois que quelqu'un, souffrant d'une insuffisance grave de l'aorte, arrive afin de faire examiner son coeur en vue d'une intervention chirurgicale, après un long

1. Hufnagel, Charles A., Harvey, W. Proctor, Rabil, Pierre J. and McDermott, Thomas F.: "Surgical Correction of Aortic Insufficiency," *Surgery*, 35:673-683 (1954).

voyage continu de 27 heures en autobus! Un lourd paletot sur le bras en plus d'une petite valise, Jacques n'a jamais pensé que fin de septembre à Washington pouvait être synonyme de température modérément chaude. Tous sont un peu étonnés aussi qu'un problème réel puisse exister au sujet de la langue que parle Jacques. Avec un degré d'instruction équivalant à une 7ième année et une étude sommaire de l'anglais, Jacques s'est imaginé que les médecins et les infirmières à Washington étaient bilingues et qu'il pouvait tout simplement parler français. Pris au dépourvu, le personnel de langue anglaise de l'hôpital, habitué à rencontrer plutôt les membres du corps médical canadien, parlant également les deux langues, doit immédiatement avoir recours à quelqu'un pouvant parler le français.

En entendant toute une variété de français, un sourire amusé apparait sur les lèvres du pauvre visage fatigué et pâle. La connaissance du français qui a très bien fait l'affaire d'un ancien professeur dans une clinique à la Sorbonne, d'un ex-GI étudiant en médecine en Normandie, d'un Cajun en Louisiane et le français qu'une des infirmières a appris dans un high-school du Massachusetts — aux oreilles de Jacques aucun n'a l'accent du français qu'on parle à Québec. Tout de même, ce ralliement de jeunes a pour effet de créer un sentiment d'amitié et de curiosité de part et d'autre.

Jacques est le troisième d'une famille catholique de huit enfants. Son père, qui s'occupe d'habitude de la direction d'un hôtel, étant malade n'a pu travailler durant l'été précédent. Sa mère, ses cinq frères et ces deux soeurs jouissent relativement d'une bonne santé. A l'âge de huit ans Jacques a souffert de rhumatisme articulaire aigu avec polyarthritie. A 13 ans, il a eu une autre attaque de rhumatisme articulaire aigu et à 16 ans il fut hospitalisé durant deux mois pour hypertension. Depuis, tous les jours il a pris une dose de digitalis, en plus de la pilule de pénicilline qu'il prend journellement depuis dix ans. Dans l'intervalle, durant les deux dernières années, il a souffert de plus en plus de dyspnée et d'orthopnée. Durant l'année qui a précédé son admission ici, il a constaté un battement systolique dans son



JACQUES

cou et sa tête, une transpiration anormale et il s'est inquiété du fait que les palpitations de son coeur devenaient de plus en plus fortes.

Sa 7ième année terminée, il a travaillé à la réparation des appareils de télévision, c'est-à-dire durant l'année précédant son admission à l'hôpital Georgetown. Après avoir reçu un premier compte de $250 à la fin de sa première semaine à l'hôpital, il s'est soudainement trouvé en face de la réalité. Ses parents n'ont jamais été en faveur d'une opération pour lui, mais il a persisté dans son intention, disant "tel que je suis dans le moment, je ne vaux absolument rien!" Il est venu en autobus avec l'intention de payer lui-même son passage. Afin de pouvoir payer l'opération qu'il espère subir, il a économisé entre $250 et $300! Après une semaine d'adaptation durant laquelle on fait l'évaluation de son

"Jacques" est un pseudonyme et c'est volontairement que nous avons omis de mentionner le nom de l'endroit où demeure le patient. Tous les autres détails sont exacts. Divers messages venant de Jacques nous apprennent qu'il a gagné 16 livres, qu'il se sent physiquement bien, qu'il travaille à la réparation des appareils de télévision et qu'il jouit de la vie d'une façon plus agréable.

coeur — une semaine de bonheur remplie d'espoir, (ses rêves: il a une petite amie et il aime les enfants; il a de l'ambition: il espère pouvoir gagner plus d'argent et il veut un jour avoir sa propre famille), imaginez sa consternation et son découragement à la vue du compte!

On dû avoir recours au Département du Service Social afin d'aider à préparer l'arrivée de la mère de Jacques, ainsi que pour parer à divers besoins qui s'avèrent nécessaires.

En supposant qu'il aurait probablement été plus facile pour Jacques d'obtenir de l'aide chez lui s'il y avait pensé à l'avance et avait établi son projet au préalable, et en tenant compte du fait que bien des caisses de secours ne sont à la disposition que des résidents de la ville, il faut maintenant trouver un moyen d'aider Jacques! Sa confiance naturelle dans les gens et une habilité indéniable pour communiquer avec eux ne peut mentir. Nous n'avons jamais douté un instant que le chirurgien (Dr. Hufnagel) ferait l'opération par amour de Dieu — mais les autres comptes? Par l'entremise du chirurgien en chef, il est possible de le traiter comme cas méritant observation et il peut ainsi obtenir une bourse du *Hartford Family*. Mis au courant du cas, le *Metropolitan Heart Guild*, un service bénévole qui accepte quelquefois de rendre des services spéciaux, accepte de payer les services d'une infirmière privée ($16 pour huit heures) pour plusieurs jours après l'opération ou tel que requis. Un autre service bénévole semblable appelé *Aids to All Charities* s'offre à payer les frais de transport — un billet de première classe par avion jusqu'à Montréal, et cetera.

La mère de Jacques emprunte l'argent nécessaire pour venir à Washington, afin de passer deux semaines avec lui, juste avant et après son opération. De nouveau, se basant sur les prix en cours dans son village, elle a tout bonnement calculé dépenser $10 par semaine pour son logement. Quand la travailleuse sociale explique le cas à la propriétaire chez qui on a l'intention de loger la maman de Jacques, une bienveillante juive d'origine russe qui a émigré dans ce pays il y a déjà de nombreuses années, non seulement accepte-t-elle d'accueillir une voisine du Canada à un taux réduit, mais faisant preuve d'un sens parfait de l'hospitalité, elle reconduit la mère de Jacques à l'autobus ainsi qu'à l'hôpital. On ne peut s'empêcher de remarquer aussi une profonde compréhension de part et d'autre et une sympathie réciproque qui semble s'être naturellement développée en prenant le café ensemble, alors que la conversation, et en anglais et en français, ne peut certainement être comprise que des interlocutrices elles-mêmes.

Soins et Préparatifs avant l'Opération

Un patient qui doit subir une valvuloplastie élective pour insuffisance aortique est d'habitude admis à l'hôpital quatre jours ou plus avant la date de l'intervention. Cette période durant laquelle le patient est sous observation permet de vérifier l'absence de toute infection — un risque très sérieux dans une telle intervention chirurgicale — et permet aussi d'étudier le patient se basant sur certains procédés servant à diagnostiquer et à pronostiquer les chances du patient sur la table d'opération. L'analyse d'urine de Jacques a montré 3 plus d'albumine avec cylindres hyalins. Hématocrite à 43; sédimentation à 3; formule blanche à 11.800 avec différenciel normal et tests sérologiques négatifs. L'azotémie s'élevait à 12 mg %. La recherche des *"C-reactive-proteins"* s'avéra négative et le titrage des anti-streptolysines s'est établi à 1/160. A l'électrocardiogramme, on trouve une hypertrophie ventriculaire gauche et de fréquentes extra-systoles. L'examen fluoroscopique du thorax décèle une aorte à pulsations exagérées tandis que l'oesophage n'est pas déplacé. Avec deux cc. de Thiomerin (un diurétique), on obtient une perte de poids de deux livres et demie. A la suite de toutes ces découvertes et de l'examen du patient par plusieurs médecins, on a posé le diagnostic d'insuffisance aortique et on a jugé que Jacques profiterait d'une valvuloplastie aortique.

On explique donc à Jacques tous les examens et procédés afin qu'il comprenne bien le but de chacun. Quoique dans un sens on ne puisse dire qu'un patient trouve agréables les examens destinés à établir un diagnos-

tic, d'une certaine façon Jacques est satisfait. On accomplit quelque chose et une telle activité est pour lui synonyme de progrès. "Je suis venu ici pour guérir et on s'occupe de moi — un, deux, trois, etc . . ."

De plus, il aime bavarder avec les infirmières, plus particulièrement avec les étudiantes: "De gentilles jeunes filles, elles me traitent comme un étudiant d'université." Elles lui enseignent quelques mots supplémentaires d'anglais — plus particulièrement certains mots d'usage courant parmi les écoliers américains, et lui leur apprend quelques mots de français. Les jeunes, quelle que soit leur langue, semblent s'accommoder facilement de sujets de conversation tels que les chansons populaires, la danse, le cinéma, les pages illustrées et les sports. Un garçon timide et bizarre à son arrivée, Jacques s'épanouit rapidement et devient un jeune homme important et plein d'assurance. Ses compagnons de chambre et leurs visiteurs partagent avec lui magazines, fruits, fleurs et télévision.

A des intervalles irréguliers, il est soumis à un régime expérimental pauvre en sel. Ceci même il trouve agréable — en partie parce qu'il l'accepte comme un moyen d'obtenir une meilleure santé et d'autre part parce qu'une marque d'attention à son égard lui est d'un réconfort moral. Pour Jacques, de manger des mets pauvres en sel et qu'on lui dise qu'il est "un brave type," cela vaut la peine. "Même si j'en ai besoin, je puis bien ne pas les manger; ce n'est pas pour qu'on me dise que je suis un brave type — nous échangeons et tout le monde est content."

L'arrivée de sa mère augmente sa joie et sa confiance; il est fier de la présenter à tous et chacun et lui sert d'interprète quand elle en a besoin. Le fait qu'elle ne veuille employer aucun mot anglais, comme par exemple "okay" ou "hello" amuse Jacques pardessus tout et il ajoute avec une étincelle dans les yeux "Une vraie française, elle ne parle pas anglais — pas un mot!" Après un moment, il ajoute "Moi, je suis français aussi, mais un Canadien-français moderne."

Au cours de la journée qui a précédé l'opération, on a déterminé le groupe sanguin de Jacques et fait la compatibilité, lui procurant 2000 cc. de sang. On a institué: quinidine chaque jour; et quatre fois par jour, pénicilline en aérosol (2 cc.-50,000 unités au cc.), associé à Tergemist. Avant une telle opération, comme patient catholique et comme c'est l'habitude, il se fait bénir. Apparemment, l'oncle préféré de Jacques est un séminariste et toute visite d'un prêtre, ou d'une religieuse, et toute pratique religieuse, comme par exemple la Sainte Communion ou une simple bénédiction, semble lui être d'un grand réconfort et lui donner du courage. Il demande et obtient la permission de conserver son scapulaire sur lui durant la durée de l'intervention et dans son lit il garde un chapelet et un crucifix.

Soins et Traitements après l'Opération

Après l'opération de Jacques, sa pression artérielle, son pouls (apical et radial) et sa respiration sont vérifiés tous les quarts d'heure pendant deux heures et ensuite toutes les demi-heures jusqu'à ce que tout se soit stabilisé (deux heures plus tard), puis chaque heure durant les premières 24 heures. Etant donné qu'on avait institué le drainage sous niveau liquidien, l'infirmière doit enregistrer fréquemment la quantité et la qualité de l'écoulement ainsi que les fluctuations dans le tube en verre. Durant deux jours on le garde sous une tente d'oxygène avec Tergemist tout en administrant un glucosé à 5 pour cent en permanence, à débit lent. Après l'intervention, on continue digitoxine et quinidine; on administre érythromycine et/ou chloromycétine de façon prophylactique; methadon contre douleurs et aspirine X gr. si la température s'élève à plus de 101°F. Les jambes de Jacques sont enveloppées dans des bandages Ace et on lui recommande de les bouger ainsi que de tousser, et de faire, chaque heure, des exercices profonds de respiration. Au besoin, on se sert de succion afin d'empêcher Jacques d'avaler des sécrétions durant les deux premiers jours.

Le jour de l'opération à huit heures du soir, on fait un hématocrite. Jacques a reçu trois chopines de sang durant l'opération. Quotidiennement, pendant quatre jours après l'opération on fait une formule sanguine complète,

un hématocrite et une analyse d'urine. On se sert d'un rayon-X portatif pour vérifier de nouveau l'expansion pulmonaire, de même que pour s'assurer s'il ne se produit pas d'épanchement thoracique.

Le premier jour après son opération, Jacques reçoit une solution intraveineuse de glucose. Le jour suivant il commence à prendre des liquides: thé chaud et coca-cola d'abord et qu'il conserve; on en augmente la quantité graduellement. Dès le troisième jour, Jacques est au régime liquide complet. Ensuite, comme il digère bien la nourriture, on lui permet de consommer 800 mg. d'une diète molle sans sel ou bien 800 mg. d'un régime normal sans sel, comme il le préfère. Comme la diète molle contient un plus grand choix de mets qu'il préfère, Jacques choisit celle-ci de préférence, pour une semaine.

La température de Jacques demeure à 101°F durant plusieurs jours après l'opération, même si les hémocultures sont négatives. On note une paralysie partielle dans son bras et sa jambe gauche. Craignant la possibilité d'une rupture vasculaire cérébrale, on institue la thérapie à l'héparine. La patient recouvre l'usage complet de son bras et de sa jambe gauche deux semaines plus tard. Une étude neurologique complète nous porte à croire que cet état passager a dû être causé par des phénomènes de compression durant l'intervention.

Après une thoracotomie postérolatérale gauche, le Département de Médecine Physique et Réhabilitation évalue le patient. Ce programme de réhabilitation a pour but d'améliorer l'alignement vertébral, de rétablir le rythme des mouvements scapulohuméraux et la capacité respiratoire. Les mouvements auxquels on soumet le patient sont les suivants:

1. Flexion complète de l'épaule.
2. Abduction du bras à 90°, coude fléchi à angle droit, suivie d'une rotation interne et externe complète.
3. Palpation des épineuses avec le pouce.
4. Position horizontale sur le dos, mains réunies derrière le cou.
5. Exercices de respiration.

Tous ces exercices sont accomplis à la limite de la douleur et de la fatigue.

A mesure que l'état général du patient s'améliore, on commence des exercices physiques et on accroît ceux-ci progressivement jusqu'à ce que le sujet soit jugé capable de participer aux activités plus dirigées du département de physiothérapie. On le soumet aussi aux tests pré-emploi. Les informations obtenues feront partie de son dossier et faciliteront le travail des moniteurs de tout autre département de physiothérapie et de réhabilitation du Québec destiné à rendre le retour au travail de notre patient possible.

Au début Jacques montre peu d'enthousiasme pour ces exercices; il veut "attendre quand je serai mieux" et ne semble pas réaliser que cette thérapie fait partie intégrale du processus. Cependant, un certain jour après les soins du matin suivis d'un repos d'une heure, on ouvre la radio à une émission de musique populaire avant de commencer la période d'exercices. Cette musique, en plus de la gaieté communicative du jeune thérapiste, réussit à convaincre Jacques et à obtenir sa coopération. Une fois le programme en cours, les nombreux compliments que ses succès lui attirent, réussissent à vaincre toute autre résistance de sa part. Si le désavantage physique dans lequel son coeur l'a placé ne semble pas l'avoir privé d'affection et d'égards, d'un autre côté il n'éprouve pas la satisfaction d'être considéré comme un homme, mais plutôt comme un "bon enfant." Ainsi le programme de réhabilitation a un double but, physique et psychologique à la fois.

Parmi les différentes coutumes qu'on lui enseigne, la nécessité d'avoir une prophylaxie dentaire lui est particulièrement soulignée. Bien qu'il ait d'autres habitudes d'hygiène personnelle solides et bien formées, le soin de ses dents semble avoir été négligé. En effet, il a plusieurs dents cariées, ne lui faisant toutefois pas mal, qu'il néglige de faire réparer et même de brosser.

Jacques, d'une nature grégaire, se plaît dans la compagnie des gens en général et ne semble jamais s'en fatiguer. Que ce soit une infirmière, un médecin, un autre patient ou un parfait étranger, Jacques adore bavarder avec eux, quel que soit le sujet de conversation. A plusieurs reprises il prolonge même la conversation jusqu'à ce qu'il ait appris ce qu'un Jamaïcain a l'in-

tention de faire à son retour chez lui, après l'obtention d'une maîtrise en chimie; comment une dame d'âge moyen confectionne au crochet un napperon dont le motif a la forme d'un ananas; et comment un fermier du Maryland s'y prend pour écorcer le tabac avant de le faire sécher. Cette facilité avec laquelle il communique avec ses semblables lui attire de nombreux amis.

Durant sa dernière semaine à l'hôpital on permet à Jacques de sortir pour dîner, ainsi que de courtes visites aux divers endroits historiques. Comme il reçoit de nombreuse invitations, bientôt la Maison Blanche, le Capitol, Lee Mansion, "Embassy Row," le Musée d'Art national, sont autant d'endroits qu'il a déjà visités. Sa dyspnée a disparue, son coeur ne "frappe" plus aussi fort, il reprend ses forces graduellement et gagne lentement quelques onces de bonne chair.

Retour Chez lui

Cinq semaines et demie sont vite écoulées. Un matin du début de novembre, par une température agréable, des amis reconduisent Jacques à l'aéroport. Après un échange de poignées de mains et de salutations il monte à bord de l'énorme avion argenté qui l'amènera vers Montréal.

De nos jours il est difficile de suivre le progrès rapide accompli dans le domaine des découvertes. C'est pour chacun d'entre nous un devoir impérieux de partager avec autrui les bienfaits qui résultent de ces découvertes. Cela demande des patients très courageux et le généreux appui des équipes médicales, afin de permettre à chacun d'entre nous de faire face à l'avenir avec confiance. Alors que Jacques disparaissait dans le ciel clair en direction du nord, cet extrait de "Salutation du Crépuscule" nous est venu à la mémoire:

Ecoute l'exhortation que t'offre le crépuscule
Aie confiance dans ce jour
Car il est la vie, la vraie vie de vie,
Dans son cours abrégé reposent toutes les vérités et
Réalités de ton existence:
L'enchantement de grandir
La gloire dans l'action
La splendeur de la beauté.
Car hier n'est qu'un rêve,
Et demain qu'une vision;
Mais de bien vivre aujourd'hui fait
D'hier un rêve de bonheur,
Et de tous les demains une vision d'espoir.
Aie confiance dans ce jour!
Tel est la salutation qu'offre le crépuscule!

A hearing loss to one member invariably involves the whole family. Misunderstandings arise, words are missed, repetition is frequent, irritation on both sides results and it is here that one should remember that an understanding of the other fellow's situation should be taken into consideration. No one wants to become irritated, but it is difficult to avoid, on the part of both parties, unless there is a desire to understand the frustration by the one who wants to be heard as well as the one who wants to hear.

The other members of the family can be very helpful to the sufferer. He will make mistakes. Don't laugh at but with him. No special consideration should be given so far as his obligation to the group is concerned. He would resent this. Expect him to carry on as before, he can stand on his own feet. Let him work out his problems in his own way. But if he pretends to hear, when you know he doesn't, let him know at once. Bluffing is bad. When he is present, always include him in the conversation — don't talk past him.

There are adjustments that must be made, certainly, but his position is one that can be just as full of successful attainment as before. Former activities should be, as far as possible, maintained. There is no point at all in withdrawing to the point of perpetual loneliness. A little extra courage, a bit more determination to use to the full what he has left, goes far to keep up that morale which is bound to maintain the proper frame of mind to carry him through to successful accomplishment. Many of the most successful people in the business, professional and every other field, have, for years, carried with them a severe hearing loss. Difficulties, yes, but the determination to succeed was uppermost and left no room for negative thinking. The frame of mind will determine the degree of success. — *The Hearing Eye*

The Pediatric Nurse and Play Therapy

PATRICIA A. PINKERTON

FOR CHILDREN, play is an essential part of growing up, of achieving physical and emotional maturity. It is the most important way in which the child can explore the world, test new skills and abilities, try new things, make new friends, learn to balance his desires and capabilities and relieve tensions.

There are many kinds of play: exploratory, dramatic, constructive and creative. A child may (and should) play alone, with other children of varying ages and with adults. Play with others provides opportunities for mental, social, physical and emotional growth.

Through play a child learns skills and gains self-confidence, as well as knowledge. He learns to adjust his wishes for group benefit, to conform to group-imposed and self-imposed rules (besides helping to formulate them), to depend upon emotional satisfactions that come from relations with contemporaries. He begins to adapt himself to the world outside his family circle, to discover in his own way the meaning of life as it applies to him.

The school-aged child is learning to become a self-directed individual. He feels a need to control himself. Instinctively, he is trying to master his fears, and satisfactorily integrate his aggressive and sexual drives into his complete personality. He becomes a gregarious person who appreciates the rights and individuality of others. He develops desirable habits of association, and the all-important ability to be a friend.

Older children need opportunities to continue their school work and learn to take responsibility in proportion to their age.

The need for play is present in all children. A sick or handicapped child needs suitable play opportunities more than he ever did when he was well. It is essential to adopt recreation to his abilities and thus fill his needs.

It is as important for the nurse to see that her patients are occupied constructively as it for her to provide them with medications, nourishment and treatments. Providing play activities tells the child that his needs are understood completely.

Acutely ill or permanently handicapped children especially need the outlets and benefits play provides. Careful thought should be given to individual abilities and needs. Ideally, some form of recreation should be provided for each child, even if the nurse must rack brains, books and supplies for appropriate ideas.

A very sick child, because of the attentions he receives, develops strong feelings of dependency and a definite attraction to the dependent state. During convalescence he requires guided play experience to help him regain independence and meet the realities of life. Without this, regression is almost inevitable and will be much more difficult to deal with in the reality than in the threat.

A child loves to help the nurses and the good this does his self-confidence more than offsets the time and trouble it costs her in providing the opportunities for him.

Meal hours afford a valuable opportunity to provide a home-like, social experience which keeps the child closely in touch with reality. Their possibilities must not be neglected.

A child reveals his thoughts and feelings in the way he plays. Careful observation can provide knowledge as to their degree of adjustment to hospitalization. By understanding their actions, the nurse can greatly improve staff-patient relationships by helping her appreciate the children as individuals. She will be more successful in meeting their needs, thus also deriving greater satisfaction from her pediatric nursing.

The nurse encourages her patients' interests when she provides them with

Miss Pinkerton was a third year student in the degree program of the University of Saskatchewan School of Nursing when this material was prepared.

play materials, which should be selected to provide further learning, and opportunities for self-expression. Play materials should be suitable to the child's age and level of illness. Besides being appealing to the imagination, more difficult activities should be encouraged to stimulate new skills. Varied toys that have a safe finish and rounded edges for individual and group play should be selected.

The child's play should be supervised, being careful not to take the initiative from him. Emphasis should be placed on what he should be able to do. Teach the child the use of tools and materials and the places they can be used, but allow him to express himself in his own way. Stereotyped activities are of little benefit. Remember that a positive approach encourages confidence but that a negative one threatens it and destroys initiative.

Hard physical play, while using a minimum of supplied material, discourages the accumulation of frustrations. It is the main way in which a child learns to master his feelings through the use of socially accepted outlets.

A hospital play program is health giving, is essential for all types of growth, prevents regression and aids in restoring the child to normal health besides helping him keep pace with his peers. Through play, with adequate suitable supervision, a child is helped to mould a wholesome personality and the character traits so important for a happy, successful life.

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In Memoriam

Margaret Annie (Dowsley) Austin who graduated in 1913 form Toronto General Hospital died on August 5, 1958 after a long illness.

* * *

A. Margaret Collie, a graduate of the Victoria General Hospital, Halifax died on September 15, 1958. She had lived in New York and practised her profession there for most of her life.

* * *

Grace Victoria (MacDonald) Cooke who graduated form Toronto General Hospital in 1943 died suddenly on July 1, 1958.

* * *

Doris (Howden) Counter, a graduate of Toronto General Hospital in 1934 died on September 8, 1958.

* * *

Sarah (Reid) Driver who graduated from Toronto General Hospital in 1913 died on August 22, 1958 after a long illness.

* * *

Jean Inglehart a graduate of Brantford General Hospital in 1924 died suddenly on September 23, 1958. She had been on the staff of the hospital for 20 years.

* * *

Willa Jean Martin, a graduate of Yarmouth Hospital, N.S. in 1939 died on October 13, 1958 after a long illness. She had been a member of the Roseway Hospital staff, Shelburne, N.S.

* * *

Viva (Thompson) Mason who graduated from Royal Victoria Hospital, Montreal in 1913 died on October 22, 1958.

* * *

Teresa (Cahill) Olsen, a graduate of St. Paul's Hospital, Vancouver in 1950 died recently after an illness of several months.

* * *

Louise (Manchester) Swan who graduated from Toronto General Hospital in 1920 died during the summer of 1958.

* * *

Everetta (Sally) Watters a graduate of Montreal General Hospital in 1910 died on October 18, 1958. She held the rank of lieutenant nursing sister, R.C.A.M.C.

Pray you now, forget and forgive.
— WM. SHAKESPEARE

I tell you the past is a bucket of ashes.
— CARL SANDBURG

RESEARCH

The Master Plan of Rotation

MARGARET M. STREET, B.A.

A MAJOR ADVANCE in modern nursing education is the increasing recognition being given to the importance of the student's clinical experience in the educational program. As an integral part of the curriculum, it must be planned with the same thought and care as are the formal classes, in accordance with sound principles of professional education. The master plan of rotation is a useful tool in such planning. Basic to the success of the master plan are two major concepts:

1. Designing and administering the master plan is the function of the faculty of the school of nursing.

2. Once designed, the master plan may not be modified to meet service demands of the hospital, that is, students may not be moved from clinical areas to which they have been assigned for experience, in order to meet nursing service demands in other areas. The master plan may be modified for educational reasons, as necessitated by circumstances affecting the individual student, for example, sickness.

After six years of experience in using the master plan of rotation, the faculty of the Calgary General Hospital School of Nursing believes that this method of pre-planning the students' educational program is sound and practical. This is not to say that there are no problems in its construction and administration, but these are minimal in comparison with the benefits derived from its use.

Miss Street is Associate Director of Nursing of the Calgary General Hospital School of Nursing.

BASIC FACTORS TO BE CONSIDERED

1. *The Curriculum of the School of Nursing*:

a. The philosophy of the school.

b. The aims of the educational program, and the kinds and amounts of learning experiences necessary to achieve the aims.

c. Regulations governing schools of nursing in the province, e.g., legal requirements specifying certain clinical experiences as prerequisites for registration.

d. Insofar as it is possible to consider these, the requirements for registration of other provinces, states, or countries.

e. Requirements for accreditation — if and when an accreditation program is established for schools of nursing in Canada.

f. The pattern of the educational program, as planned by the faculty for each class.

2. *The nature of the learner*: The following factors should be considered, in relation to designing the rotation plan for the individual student:

a. Her background, as far as possible and practicable: general education, social influences — family, community, church.

b. Intelligence level.

c. Age level and degree of maturity.

d. Adaptability: adjustment to the school of nursing, to communal living, to the clinical situation.

e. Readiness for certain experiences at a given time, for example, operating room.

f. Her aims, needs and motivation.

g. Problems — physical, psychological, social, or other.

The Nature of the Learning Process and Principles of Learning: It is desirable in constructing the master plan of rotation to be mindful of both the principles of learning and the nature of the learning process.

a. Learning is manifested by changes in behavior; changes in behavior resulting from experience rather than merely from the process of maturation are the essence of learning; and a student has not really *learned* unless the changes in behavior persist.

b. Learning takes place more effectively when a student is *ready to learn*. Both psychological and physiological readiness are important. Thus, certain students may be ready for the operating room earlier than others in the same class.

c. Individual differences must be considered.

d. Motivation is essential for learning.

e. What the student learns in any given situation depends upon what she perceives. A student learns what she actually uses.

f. Learning takes place more effectively in a situation where the student derives feelings of satisfaction.

g. Recognition of similarities and dissimilarities between the past experience and the present situation facilitates the transfer of learning.

h. Interpersonal relationships are important in motivation and determining the kind of social, emotional and intellectual behavior which emerges from the learning situation.

i. Evaluation by both the student and the teacher is essential to determine whether desirable changes in behavior are taking place.

It will be noted, by a thoughtful examination of the above principles, as stated by Ole Sand, that they contain many indications as to the placement of experiences for individual students, and the guiding of the learning process in the clinical areas to which she is assigned.

4. *Criteria for a well organized curriculum*: In planning the students' clinical experience, the criteria for a well organized curriculum are also to be borne in mind. These have been stated in the same source noted above:

Continuity:—Reiteration of major curriculum elements which can serve as threads running from the first year to the last, to tie the learning experiences together.

Cooperative planning by the faculty of the school of nursing, in relation both to master plan construction and teaching programs in various areas of the curriculum, will be necessary in order to ensure continuity of learning experiences for the student.

Sequence:—Is related to continuity, but goes beyond it. Each successive experience is not only built upon the preceding one, but goes more broadly and deeply into the matters involved. Higher levels of treatment are involved.

Thus, sequence of clinical experiences is important, in master plan construction. Desirably, these proceed from the simple to the complex. It is a tribute to the master plan of the educational program when a student remarks, at the end of her course "I felt that I was ready for each new clinical experience as it came along; one experience seemed to lead to the next." To preserve the principles of continuity and sequence, tools and techniques are developed whereby the teachers in the wards are able to ascertain readily the level in the program of students assigned to them, and the experience background of each student to date, as well as their present learning needs.

Integration: — Helping the student to get a unified view and to unify her behavior in relation to the elements dealt with.

In commenting on this criterion, one would note that such experiences provided in the senior year, e.g., a final period in general medical and surgical nursing, a rural hospital affiliation, experience in the emergency ward, etc., provide excellent opportunities for the student to integrate her learning during the basic course.

5. *Availability of the clinical experiences required to realize the aims of the education program*: Before commencing to construct the master plan of rotation, it is necessary to assess the available clinical resources afforded both by the home school and by affiliation with other schools and with community health and welfare agencies.

Sand, Ole. *Curriculum Study in Basic Nursing Education*, New York, 1955, G. P. Putnam's Sons.

6. *Adequacy of the available clinical resources*: This is judged by:

a. The *quantity* of experience available — the absorption power of the wards, departments, and agencies, in relation to the number of students requiring the experiences.

b. The *quality* of experience available, based on various factors, such as the variety of clinical conditions essential to provide a well-rounded experience, activity of the clinical services, length of patient stay, etc.

c. The *staffing* of the nursing service in areas in which students are to receive experience, so as to ensure good patient care and to safeguard the educational program for students:

adequate numbers of registered nurses and auxiliary nursing personnel to stabilize the service.

qualified head nurses and supervisors, to promote best utilization of resources, including staff.

availability of qualified clinical instructors in all clinical areas, to plan, direct, and supervise the educational program in the wards.

d. Close working relationships between the nursing service and the school of nursing, with deep mutual understanding of the aims of service and school, and mutual support one of the other.

7. *Desirability of maintaining uniform numbers of students in wards or services at all times*: Insofar as this is consistent with the learning needs of the individual students; the importance of the school of nursing advising the nursing service, well in advance of a budget period, of the maximum numbers of students anticipated weekly for assignment to each clinical area for the budget period.

Construction of the Master Plan

Bearing in mind the basic factors governing the planning of students' clinical experience, the actual steps in the construction of the master plan for each class are as follows:

1. The faculty of the school of nursing designs the educational program for the class entering the school:

a. Program of theorical instruction is planned — courses, hours, placement of courses, pattern of instruction (block, modified block, study days, correlated instruction given during experience in clinical area).

b. Length of clinical experience in each service is determined, and whether the experience is to be taken at one time, or at various levels throughout the program. Method of securing correlation between theoretical instruction and experience is discussed.

c. Sequence of clinical experiences is recommended.

d. Recommendations are made by clinical instructors regarding desirable frequency of rotations into each ward or department.

e. Programs of special groups are considered, e.g., students affiliating from schools of nursing situated in special areas such as, mental hospitals, universities, etc. Requirements of the curricula in schools sending affiliates are reviewed.

2. The faculty member responsible for student nurse rotations then prepares the master plan of rotation for the new class. This may be done two or three weeks following admission.

The Nursing Arts Instructors are usually responsible for assignment of students to wards, for one or two hours daily, during the first term, September-mid-November inclusive.

Hence the Master Plan is designed to cover the program from the *fifth to the thirty-sixth month* inclusive. *Names of students* are placed on the plan late in October, after there has been an opportunity to evaluate the specific potentialities and needs of the individual student.

3. *Procedure in making Master Plan*:

a. Secure suitable graph paper.

b. Fasten sheets together, using gummed tape on the back of the sheets to make one large sheet, big enough to accommodate the names of all students, and one graph square for each of the weeks for which the program is planned.

c. Leave on the left a column for students' names, and place number opposite each space, including all students in the class.

d. Along top of sheet, place the dates for the beginning of each week, for the entire period of the basic course.

e. Block out the periods of block instruction or major curriculum areas,

for the entire period of the basic course.

f. *Plot affiliations*: If one class is taken into the school yearly, each class is entitled to the equivalent of one year's experience in any given affiliation.

If four students are sent every eight weeks for affiliation at the provincial mental hospital, (52/8) or 6½ rotations are made yearly into this area, which means that (6½ x 4) or *26* students may have this experience yearly. Thus, if one class enters yearly, 26 students of that class may have the affiliation and provision for this will be made on the Master Plan. If two classes should enter yearly, each class will have a proportion of 26, depending on the size of the class.

In placing the affiliations on the Master Plan, thought must be taken of prerequisites for each affiliation, and its placement in the educational program.

It goes without saying that affiliation contracts must specify the number of students who may affiliate at one time, and the home school must keep faith with the affiliation agency. This means a steady inflow of students. In making the Master Plan, affiliations for the new class will follow immediately those of the preceding class, without break in continuity.

g. Plot the remainder of the rotation plan, service by service. Here, as with affiliations, each class is entitled to one year's share of a given experience, e.g. Diet Kitchen or Emergency. Again, one Master Plan must dovetail with the preceding one, so that there is a steady inflow of students into the various clinical areas.

Planning the rotation for any one service

1. *Analysis of the absorption power of the service*:

This may be done by various methods. Information required:

a. daily average of patients in the ward *or* number of patient days, month by month, for a twelve-month period;

b. standard hours of care approved per patient day, for that ward or service;

c. seasonal fluctuations in census, if any;

d. percentage of care to be given by *professional* (graduate and student) and *non-professional* nursing personnel;

e. percentage of professional care to be given by *graduate nurses* and by *student nurses*;

f. *hours of teaching time* for students weekly;

g. *hours of duty* for students weekly;

h. *effectiveness factors* of students at various levels in the program, i.e. value of student service in terms of graduate nurse effectiveness;

i. *hours worked* daily, weekly and yearly by graduate nurses and auxiliary nursing personnel.

Example: Ward A is a Women's Medical ward of 30 beds, with a daily average of 25 patients. Patient days yearly are 9125, and the census remains fairly constant throughout the year. Standard hours of care approved for this ward are 3.4 per patient day. Of the general nursing care given, 65% is to be given by professional and 35% by non-professional nursing personnel. Professional hours of care include those given by general staff nurses, and hours of student nurse service, equated in terms of graduate effectiveness. Effectiveness factors recognized in this hospital and school of nursing are: Senior students, 90%; intermediate students, 75%; and junior students (after the first eight months) 50%. Junior students, during the first four months have an effectiveness factor of 0, and during the next four months (Medical-Surgical block period) 33⅓%. Of the professional care given, half is to be by general staff nurses, and half by student nurses.

General staff nurses give *1844* general nursing hours yearly, exclusive of weekly, annual and statutory holidays and average sick time.

Certified Nursing Aides give *1912* bedside nursing hours yearly, exclusive of holidays and sick time.

Students have a 48-hour week, including 3 hours of class time and an average of 2 hours of "allowable" sick time. Bedside nursing hours weekly, therefore, total *43*.

To compute the numbers of students who may be rotated through this ward weekly and yearly: Number of bedside nursing hours required yearly, i.e. for 9,125 patient days, at 3.4 hours per patient day: 9,125 x 3.4 = 31,025

Number of hours to be given by *professional* personnel: 65% x 31,025 = 20,166

Number of hours by *non-professional personnel* = 10,859

Half of professional nursing care, or (20,166 ÷ 2) or 10,083 hours are to be given by general staff nurses.

General staff nurses required: (10,083 ÷ 1844) = 5.4 (5.6)

Half of professional nursing care is to be given by students, or 10,083 hours.

Of this, one-third is to be given by seniors, at 90% effectiveness; one-third by intermediates, at 75% effectiveness; and one-third by juniors at 50% effectiveness.

In order to give 3361 professional nursing hours, senior students would have to give 100 ÷ 90 x 3361 or 3734.4 hours.

In order to give 3361 professional nursing hours, intermediate students would have to give 100 ÷ 75 x 3361 or 4481.3 hours.

In order to give 3361 professional nursing hours, junior students would have to give 100 ÷ 50 x 3361 or 6722 hours.

One student would give 43 hours weekly x 52 weeks in year or 2236 student bedside nursing hours yearly.

Number of *senior students* who could have experience at all times in Ward A throughout the year, would then be 3734 ÷ 2236 or 1.06 (1-2)

Number of *intermediate students* who could have experience at all times in Ward A throughout the year, would then be 4481 ÷ 2236 or 2.0

Number of *junior students* who could have experience at all times throughout the year would be 6722 ÷ 2236 or 3.0

Total number of students who could receive experience at one time in this ward would then be seven.

Number of *non-professional* nursing personnel required (10,859 ÷ 1912) or 5.6 (5-6)

2. *2nd Step in Planning Rotations by Services*

Estimate the numbers of students of this class who should be in the particular ward or service at one time, by taking the length of experience required by the curriculum plan. For example: Diet kitchen — 6 weeks. This would make (52 ÷ 6) or 8 2/3 rotations yearly. If one class yearly is admitted, then for a class of 100 the number who should be in the diet kitchen at one time should be (100 ÷ 8 2/3) or 11.5 (11-12). If students are sent into the diet kitchen every two weeks, four will be sent at one time.

3. Check the number of students who should be sent into the given clinical area against the known absorption power of the service. If the number should exceed that which can be accommodated satisfactorily, this is a problem which should be considered by the faculty as a whole, and by the administrative officials of the hospital and the school of nursing. (Such a problem should be detected *in advance* of class admission).

Solution of this problem may be sought and found in various ways:

a. By decreasing the length of time students will spend in the area, always considering, however, the minimum time necessary to satisfy registration requirements and the learnings needs of the students.

b. By expanding the clinical facilities in that area, for example, in the case of diet kitchen — using the wards as the laboratory for student experience. This would necessitate a teaching dietitian on the wards.

c. By seeking resources for student experience in the community health and welfare agencies.

4. Having determined the number of students who should and can be rotated at one time into a given service, and the frequency of such rotation, plan the rotations for that service for the entire class, making sure that the first students go into the area at the correct time, to "link up" with those of the previous class completing their experience therein.

5. Plan the rotations for every other required service in a similar way, one after the other.

6. Plan holiday times so as to space these as evenly as possible through the holiday months. Holiday months will be planned to avoid periods of heavy class schedules, and periods of depletion of available student service for other reasons

e.g. class graduating at end of August; new class having no "service" value for fall months, September-December.

7. *In planning rotations, endeavor to arrange for practice in given clini-*

cal services as soon as possible following the classes in the related subjects. Studies have shown that a typical student will forget 50% of what she learned, after the first year, and 75% after the second year, unless opportunity to apply and consolidate learning in practice has been provided.

8. While the Master Plan is still in the draft stage, have it reviewed by the associate director of nursing education and individual instructors concerned. If there are matters arising out of the evolving plan which are of particular concern or interest, have it reviewed, before finalizing, also by the other persons who may have some relationship to it, e.g. the director of nursing, the associate director of nursing service, the director of nursing (or her representative) of the school or schools sending affiliates, etc.

9. Also, before finalizing the Master Plan, make a summary of the experiences (in weeks or days) for all students provided therein. This is essential, to make sure that the curriculum "prescription" has been followed and achieved.

10. Before putting the students' names on the plan, the following steps may prove helpful:

a. The faculty member who made the plan may speak to the class, usually in groups, about the experiences which have been included therein, their length, sequence, and relationship to the total curriculum.

b. She may invite the students to express their preferences for or against certain affiliations; and to state any reason for preferences in regard to annual vacation.

c. Requirements of certain students or groups of students for certain experiences will be considered, and these will be interpreted, also, in speaking to the students.

d. Through the associate director of nursing education, in conferences with both classroom and clinical instructors, an evaluation will be secured of the development of the various students to date. Emotional maturity and readiness for certain experiences (e.g. operating room) will be ascertained. Care will be taken, in putting the names on the plan, to provide combinations of students which will make for most effective development of the individual student. The service, too, is considered in this arrangement. One advantage of having, in groups of students, some "good", some "better" and some "best" is found in the withdrawal factor: it is important, both for school and service, that large withdrawals should not take place from one area of the Master Plan.

11. Considering all of the foregoing factors, the students' names are then put on the Master Plan.

12. Each student's plan is then discussed with her individually, and she is advised that it will be in order for her to see it at any time.

13. The completed plan is then reviewed by the faculty, the head nurses, supervisors, and others to whom it should be interpreted.

To be concluded next month

Alive and Well

The many friends of Mrs. Ruth A. Hillman, a 1950 graduate of Hamilton General Hospital, will be delighted and thankful to know that she is still very much alive. An item reporting her death was included in our November issue following the receipt of erroneous information.

Mrs. Hillman is currently enrolled in the course in public health nursing at the University of Western Ontario, London.

Plans for retirement should include more than dreams of travel or just loafing. A few weeks of idling can lead to boredom, an undesirable condition for older retired people. Prepare for hobbies and interesting occupations when you leave work.

Nursing Profiles

Last October a valued member of the nursing profession retired from active service when **Ethel Cryderman** left her position as District Director of the Toronto Branch of the Victorian Order of Nurses, one that she held since 1934. During that time she saw this branch survive the hardships of the depression years, the stress of World War II and the unprecedented growth of the Toronto area with its attendant changes and problems. Under her direction the work of the Toronto Branch has more than doubled. Its standard of nursing service has been raised and new functions have been added until today it has a reputation for providing a high calibre of community nursing service. This achievement is recognized by her colleagues as a reflection of Miss Cryderman's able administration. Her years of service have been characterized, too, by a sharing of her experience to provide preparation for other nursing leaders. Many nurses who worked with Miss Cryderman now hold key positions in Canadian nursing.

Miss Cryderman's capacity for hard work is evident in the responsibilities that she has assumed in addition to those of her job. She has been active throughout the years on innumerable committees in community-wide organizations. As a member of the board of directors of the Community Chest and as a member of the Welfare Council her dynamic thinking has contributed in no small measure to the development of the health and welfare services of her community.

The Canadian nursing profession as a whole has been greatly enriched by Miss Cryderman's generous sharing of her talents. She has been chairman of, and associated with, numerous committees of professional nursing organizations — local, provincial, national and international. In addition to being president of her own alumnae association and of the Registered Nurses' Association of Ontario, Miss Cryderman assumed the heavy tasks of president of the Canadian Nurses' Association from 1948 to 1950.

A graduate of Toronto General Hospital, Miss Cryderman received her certificate in public health nursing from the University of Toronto. She obtained further training in midwifery at Radcliffe Infirmary, Oxford, Eng. and in mothercraft in London.

Miss Cryderman saw military service with the R.C.A.M.C. during World War I, was a staff nurse and district supervisor with the Toronto Department of Health and, from 1929 to 1934, she was a central office supervisor with the Victorian Order of Nurses for Canada. During this time she organized and conducted institutes in maternity nursing throughout Canada.

Miss Cryderman looks back with great pleasure on the many vacations that she has spent canoeing and hiking in the Canadian outdoors. In spite of her busy life she found the time and energy to gain enough experience in mountain climbing to make her graduation climb. Reading has always claimed her interest and she enjoys sharing her reading experiences through discussion.

Her dynamic leadership will be sadly missed by those who have worked most closely with her. But all who know her will rejoice with her that she can now enjoy a more relaxed life. Her warm interest in people will remain and guarantee a continuing absorption in nursing and community affairs.

ETHEL CRYDERMAN

Irene Bernice Seeds is the new district director of the Toronto Branch of the Victorian Order of Nurses. A graduate of Toronto Western Hospital in 1938, Miss Seeds obtained her Bachelor of Nursing from McGill University's School for Graduate Nurses in 1947 and her certificate in administration and supervision from the University of Toronto in 1951.

Following her graduation from T.W.H. she remained on staff for several months before engaging in private duty for a short time. Then World War II began and Miss Seeds joined the R.C.A.M.C. in September, 1939. During the next six years she served

in Canada, England, North Africa and Italy. Upon her return to Canada, she entered McGill University for postgraduate work and joined the Victorian Order of Nurses as a staff nurse in Vancouver upon completion of her studies. A year later she came back to her native province, Ontario, where she joined the Northumberland-Durham Health Unit. Her next move was to the Toronto Branch of the V.O.N. where she has served successively as a senior nurse, second and first assistant director.

Membership in the Nursing Sisters' Association, Toronto Unit, keeps her in touch with friends who shared her wartime experiences. Off duty Miss Seeds likes to try her luck at fishing or photography. The best wishes of her friends go with her as she begins her new duties of directing the activities of this busy V.O.N. branch.

The University of Western Ontario School of Nursing has announced the appointment of **Ruth Catherine Aikin** to the faculty where she will teach in the nursing education program. Born in Prince Albert, she received her early education in Winnipeg and Westmount, P.Q. A graduate of the Montreal General Hospital in 1938, she engaged in staff and private nursing for some time and then took up occupational health nursing with Canadian Car Munitions Ltd. in 1941. Three years later she joined the R.C.A.M.C. and eventually went to England with No. 11 Canadian General Hospital.

Following her discharge from the services Miss Aikin entered McGill University for postgraduate study. She completed requirements for her B.A. in 1948 and for her B.N. in 1949. A year at M.G.H. as instructress of nursing was followed by appointment to the staff of the Quebec provincial office where she became the assistant secretary-registrar of the A.N.P.Q. In 1952 she went to Calgary General Hospital as educational director where she remained until she accepted her present appointment.

Van Dyck — Montreal

R. Catherine Aikin

With the retirement of **Dora Parry** from the position of director of nursing — a role she has filled since 1938 — the Montreal Children's Hospital bids a reluctant farewell to one of its most devoted members.

Dora Parry

The Children's Memorial Hospital has been a part of Miss Parry's life since she first entered its doors as a student nurse in 1921. Immediately upon graduation she joined the staff first as acting night supervisor and then successively as operating room supervisor (1924-30), acting superintendent for a few months, assistant superintendent (1936-38) and superintendent (1938-58). One year was spent at the McGill School for Graduate Nurses while Miss Parry secured her certificate in administration in schools of nursing. In 1935 she returned to England for a year's visit — Miss Parry was born in Wigan, Lancashire.

Through the years she has watched her hospital grow in prestige as well as physical size. Although the hospital discontinued the training of nurses some time ago, nursing education is one of its major functions. Hundreds of student nurses from hospitals throughout the province have received

their experience in the care of children under the guidance of the teaching staff. The pediatric program for students of medicine is recognized by universities as one of the best of its kind. More recently developments in cardiac surgery and the successful treatment of children with heart lesions have brought the hospital to the attention of the general public.

It must have been with a sense of deep pride and accomplishment that Miss Parry took part in the move from the buildings perched on the side of Mount Royal to the spacious and modernized quarters of the hospital's new site in downtown Montreal. Some time before that event, the familiar name of "Children's Memorial Hospital" was replaced by "Montreal Children's Hospital." No doubt this change brought twinges of regret to some, but it is in keeping with the general development of the hospital in medical life.

In 1946, a milestone in Miss Parry's professional career — her 25th year of association with the hospital — was marked by appropriate celebration. Now her friends and colleagues are recognizing another milestone in her life and their good wishes will follow her into the future.

Occupational health nursing within recent years has come to be an important branch of our profession. Managers in industry have recognized the value of the nurse in reducing absenteeism due to illness and maintaining the general efficiency of the plant. No doubt the workers have come to appreciate more and more the presence of one whose sole interest lies in them. The scope of the work of the average nurse in industry can be illustrated by the career of **Yvonne Martel** who is presently the occupational health nurse at the Miner Rubber Company Ltd., Granby, P.Q.

A graduate of Misericordia Hospital, Montreal, Miss Martel gained knowledge of nursing in industry through special courses of study in Montreal, Ottawa and Boston, Massachusetts. One of her first assignments was to organize First Aid units for the Foundation Company of Canada, Shipshaw, P.Q. This was done at a time when the plant was organizing for wartime production. Later Miss Martel undertook a somewhat similar task at St. Paul l'Ermite when she organized a company hospital. She has, since then, set up First Aid units for the Julius Kayser Company of Canada, Sherbrooke, P.Q. and spent some time in occupational health nursing in British Columbia. After joining the Miner Rubber Co., she reorganized First Aid facilities for the employees.

The young graduate with an interest in public health nursing would find the field of occupational health nursing a very stimulating one.

Measurement of Sound

The unit of sound measurement is the decibel. The decibel scale progresses from a zero reading when no sound exists to a reading of 110, at which level sound is so intense as to be painful. The most active hospital areas may have a decibel level of between 50 and 70. With acoustical treatment, such a level can be reduced as much as 10 decibels.

DECIBEL SCALE

110 — Threshold of pain
Thunder, artillery
100
90 — Newspaper press room
Jackhammer drill at 10 ft.
80
70 — Average machine shop
Stenographic room
60
50 — Congested department store
Average restaurant
40 — Average schoolroom
Quiet automobile
30 — Public library
Quiet residence
20 — Rustling paper
Average whisper
10
0 — Threshold of hearing

— National Gypsum Company

* * *

A good education is the passport to the great adventures of life. But to really enable us to go places that passport must be stamped again and again with the visas of experience and continuing education.

— WALTER CISLER

* * *

A closed mouth catches no flies.

— MIGUEL DE CERVANTES

Faith and Loyalty

MARTHA RILEY

"LOYALTY IS A BEAUTIFUL WORD, and it means the quality of being constant and faithful in any relation implying trust or confidence — of bearing true allegiance to constituted authority, of professing faithful devotion."[2] Faith is confidence, as faith in yourself, faith in God, faith in your family and friends, and faith in your profession. These so closely related virtues of faith and loyalty are necessities for every person in every walk of life. "Loyalty implies being faithful,"[4] therefore, if you have faith, it also follows that you will be loyal.

Regardless of who you are or what your position and status in life may be, before you can be faithful and loyal to anything or anyone, you must be faithful and loyal to yourself. You are an individual, a personality in yourself — there is no exact duplicate of you anywhere in this universe, as no two personalities are exactly alike. Before you can satisfy any of your dreams, you must have faith in what you are reaching for and you must be loyal to that aim, no matter how difficult the road may be. Whether your fondest desire is to take a trip around the world or to be the finest nurse yet, you must have confidence in yourself and believe in what you are doing. Before you can be truly faithful and loyal to yourself, you must develop the additional traits of dependability, sincerity, and gratitude. It is one thing to know the importance of being faithful and loyal to yourself; it is quite another thing to carry it out. Always remember that it is yourself that you have to live with all the days of your life.

The Bible tells us that "Faith is the confidence of things hoped for, the evidence of things not seen."[3] Further it tells us that "Without faith it is impossible to please Him: for he that cometh to God must believe that he is, and that He is a rewarder of them that diligently seek Him."[3] Your religious beliefs begin to develop in very early life, as they are influenced by your parents and your environment. Your religious beliefs should be your strongest beliefs — ones to which you will hold long and fast, regardless of how tough the going may be. It is so important to have faith in God and to be loyal to Him, for He is a part of each one of us.

Faith and loyalty towards your family and friends are very important, for they are the ones closest to your heart, the ones in whom you want to be able to confide. Your family has been with you since the beginning of your existence, and you owe a great deal to them. Your true friends have stayed and will stay with you through thick and thin. They deserve your faith and loyalty. Trust them — have confidence in them — know and believe that they are trying to help you and do what is best for you. Remember that the advice that may seem so wrong at first, is, in the long run, so often the best advice you will ever receive. The faith and loyalty that you show towards your family and friends will be sincerely rewarded for they will return that faith and loyalty to you.

Behind the desire to become a nurse, there must be a great deal of faith and loyalty. The road that leads to "R.N." is far from an easy road, but it will be a very rewarding one if it is travelled with these qualities ever before you. The nurse must be faithful and loyal towards the ideals of life, the patients, the nursing profession, her fellow students, the doctors, her superiors, the school, and the hospital. She must have confidence in all of these so that she will be able to inspire confidence in others. Not every nurse can be at the top of her class, but every one can be faithful to the trust that is reposed in her. "A nurse can receive no higher recommendation than 'Thou hast been faithful.' "[1]

In summarizing the attitudes and principles of faith and loyalty, it might be well to review the admonitions

Miss Riley is in her first year in training at Misericordia Hospital, Winnipeg, Man.

given by Florence Nightingale:[5]

> And remember, every nurse should be one who is to be depended upon, in other words, capable of being a 'confidential' nurse. She does not know how soon she may find herself placed in such a situation; she must be no gossip, no vain talker; she should never answer questions about her sick except to those who have a right to ask them; she must, I need not say, be strictly sober and honest; but more than this, she must be a religious and devoted woman; she must have a respect for her own calling, because God's precious gift of life is often literally placed in her own hands; she must be a sound, and close, and quick observer; and she must be a woman of delicate and decent feeling.

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Health Work on Okinawa

SISTER MARY CARMEL, F.M.S.I.

KAZUKO ANGELA SAKIKARA is Okinawa's only Catholic Child's Welfare worker. Kazuko's family live on Yaeyama Island. We first heard of Kazuko in 1955 when she was in Tokyo completing her college course. She had undertaken college on her own savings and at the beginning of her senior year she realized that her money would not hold out. At first she considered going back to work until she had saved enough, but then she decided to write to her brother and ask him to go to the Mission, and explain her situation. If the Mission would see her through her last year in college, she promised that she would return to Okinawa and help in its work. The result was that Kazuko's senior year was made secure.

Kazuko and Sister

In 1956 Kazuko returned to Okinawa and joined the Child's Welfare Office. She has been a valuable asset to the Mission. Her friendly, easy manner soon puts the poor abandoned people with whom she works at ease.

One Saturday morning we picked up Kazuko at her office to take her to see one of our home patients, Takamine-san. We wanted to obtain the correct and necessary information so that the family could receive government help. As soon as she was settled in our little car, Kazuko started a lively conversation that lasted as long as the ride. As we drove slowly along the narrow road attempting to keep our car out of reach of small children and their little pals — small

---

Sister Mary Carmel is the superior of The Mission conducted by the Daughters of Mary, Health of the Sick of Vista Maria, Cragsmoor, N.Y., on the outskirts of Naha, capital of the war-famous island of Okinawa. From Barnaby River, N.B., Sister is a graduate of Hotel Dieu, Chatham, N.B. She has worked at Halifax Infirmary, Ottawa Civic Hospital and St. Joseph's Hospital, Saint John, N.B.

puppies — Sister Mary Annunciata and I recognized a young friend, Eishin, a boy about 12 years old. Just as we slowed down to greet Eishin, Kazuko called out excitedly "That's one of my boys! Stop! Stop!"

Sister brought the car to a complete stop to get the situation clear. It turned out that Eishin was a child welfare case. He and his father live alone. His father loves him very much but he loves "sake" too. Because of this latter love the poor man spends a good deal of time in the local jail. During these times Eishin is cared for by child welfare and goes to school every day. But as soon as his father is free, the first thing he does is bring Eishin home which always ends his schooling. The father just doesn't seem to understand that his son should be in school.

We all went with Eishin to have a word with his father. As we opened the door of the one-room home, we were met by a strong aroma of sake. The man we wanted to talk to was sound asleep. We succeeded in awakening him and he quickly sat up, bowed and smiled pleasantly. Kazuko began giving him a little advice and stressed the importance of sending Eishin to School. The gentleman agreed with every word, but I think he was glad when we left, so he could go back to sleep and Eishin back to play.

The little boy often visits our clinic and we give him lunch. When we mention school, he is always just going or just coming from there. He has little love for studies.

We finally continued on our way to see Takamine-san. After five days of continuous vomiting, he was happy to hear that there was a chance to admit him to a government hospital. Takamine-san's wife died a few months ago. Since then he has been very sick. Trying to care for his two children — a little girl, 10, and a boy, 7 — was a constant worry.

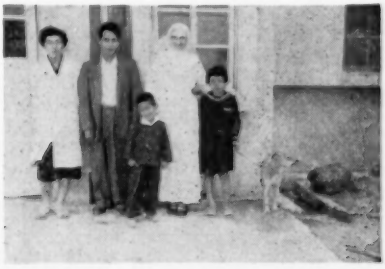
That day the little boy was sick too. His tiny bed took up most of the floor space. The small girl tried to help her father. They had a little dog too, and the house was so cramped that we had to let him out to get in. The kitchen was out behind the house in a cave dug in the hillside. Each time we have visited we have taken them food, otherwise there never seems to be any food around. Maybe the little girl goes to market for something just before they need it to prepare a meal.

Cooking out of doors

Eventually, with Kazuko's help the necessary government forms were in order. Takamine-san was admitted to the hospital for surgery.

The children were heartbroken when they had to leave their father. The boy held on to the dog so determinedly that the welfare officials allowed the children to bring him along. The next time we visited the children we got the usual greeting from the dog who was tied with a short rope outside the building. We were told that he was

Visiting a sick boy



Going home from hospital

eating well and growing. The children were happy and going to school regularly. But when we visited the father — the hospital was right next door — he cried almost all the while we were there because he was so lonesome for the children. Surgery was scheduled for the following morning. We gave him some candy and games to give the children when they came in to see him before operation.

About four days after surgery we visited Takamine-san again and found that he was making wonderful progress. He was all smiles and very happy over the success of the surgery.

Takamine-san and his family did not return to their former home. The government rented a big room for them. We are continuing to visit him regularly and he is getting along most happily.

The Venereal Disease Clinic

MAGDALENE SCHROETER

ONE MONDAY we were scheduled for a field trip to the Venereal Disease Clinic which is held at the Outpatient Department of St. Boniface Hospital. This was part of our course in community health. The purpose of the visit was to point out the ways in which the problem of venereal disease is handled by health authorities in the City of Winnipeg in order to give us a better insight in the different aspects of V.D., to understand the importance of such a department for the affected person in particular and the community as a whole, and to give us an opportunity to observe the ways by which this plan is carried out in practice.

We reported to the public health nurse on duty, who in turn introduced us to the physician in charge. The doctor gave us an outline of the medical treatment of both gonorrhea and syphilis, pointing out the difficulty in making a clinical diagnosis for gonorrhea. He mentioned the sugar-fermentation test which is a specific laboratory test for gonorrhea, differentiating the causative organism of this disease from other non-specific, gram-negative, intracellular diplococci which often erroneously are thought to be gonococci. This may happen in young girls who have a vulvovaginitis the smear of which contains gram-negative intracellular diplococci. In men, on the other hand, there sometimes are the symptoms of Reiter's syndrome which lead to a wrong diagnosis. The latter is typical of urethritis, conjunctivitis, and arthritis thus mimicking the symptoms of gonorrhea but caused by a non-specific organism.

In general, the diagnosis of gonorrhea is established only after the laboratory report from the smear taken, comes back, but treatment is started at once on the basis of clinical findings. A very large dose of penicillin — six billion units — is given to combat lues plus two million units to combat gonorrhea since these diseases are often found simultaneously in one person. In lues up to nine million, even 12 million units will be given or courses repeated where indicated. Wassermann tests are taken routinely on every patient whether he comes in for the treatment of lues or gonorrhea.

Before treatment with penicillin is started, the patients are always questioned whether or not they know if they are allergic to the drug. Should this be the case, then terramycin is substituted for penicillin. The disadvantage of the latter treatment is the high price of terramycin. When the patient comes in for his injections he is asked every time for signs and symptoms of allergy such as pruritus, etc.

The treatment of syphilis also includes a general physical examination and an examination of cerebrospinal

Originally from Germany, Miss Schroeter was a student at Misericordia Hospital, Winnipeg, when this report was written.

fluid if indicated. Blood tests are repeated for six months or until the tests are negative. Follow-up treatment is carried out over a number of years in order to detect any clinical or serological relapses. If the patient during his treatment should develop any other illnesses, the doctor refers him to the appropriate department of the O.P.D. or may even admit him to hospital if necessary. Even with early treatment of gonorrhea, arthritis is sometimes a complication which might require hospitalization or physiotherapy.

The clinic on this particular morning was not too well attended, but nevertheless we had the opportunity to be present at an interview conducted by the public health nurse with one of the patients. The patient was a young man, 24 years of age, who was being treated for the second time for gonorrhea. The nurse, after explaining to him that all his answers would be kept strictly confidential, tried to get the required information about his contact, but his description was very vague and nonspecific. He was urged to avoid further contacts with unknown people and was given some educational pamphlets about V.D. He also was asked to try and find out the full name and address of his contact so that the public health nurse could visit her and suggest a course of treatment in order to prevent further spread of the disease from this source.

The information obtained from the patient was put on a form, one copy of which is sent to the Department of Health in Winnipeg and the other one to the Police Department. Although, as pointed out by the nurse, not all the contacts can be traced all the time, it seldom is necessary to force people. Reports are only sent to the police on those who are brought to the clinic by morality officers; not on other patients.

Patients visiting the clinic in general belong to the low — or medium-wage groups. Most of the female repeaters are Indians or half-breeds who come from outside the city, are ill-adjusted and most often not too fond of work. Some of them deliberately ask to be put into jail where there is also an opportunity to receive treatment for venereal diseases. Unfortunately, there does not exist any organized rehabilitation program for these prisoners so that there is great likelihood that they will resume the way of life they led before imprisonment after they are released.

Poor housing, inadequate education, lack of work, and alcohol, all are unfavorable factors influencing this group of people and increasing their promiscuity. Some of the female patients who are committed through the Juvenile court are detained in a sheltering home. Twice a week the public health nurse from the V.D. clinic visits these homes to take smears, cultures or blood tests and to give antibiotic treatment to those affected with venereal diseases.

It sometimes also happens that one of the patients is pregnant. If she is not married she is referred to a hospital where she can stay until delivery and where she has close medical supervision throughout her pregnancy. Plans for adoption if desired will be taken care of in these hospitals.

All services of the V.D. clinic are free of charge. The provincial government pays an annual flat rate to St. Boniface Hospital which in turn supplies the nursing services. The drugs for treatment are supplied by the federal government. The staff consists of the physician-in-charge, two nurses and one clerk. Clinics are held twice a week in the morning and afternoon for both men and women, on Monday evenings for men and Thursday evenings for women.

The purpose and aim of the clinic is, of course, to give early treatment to all infected persons and by tracing their contacts to discover all other cases suffering from V.D. The clinics, although one of the most valuable divisions in the fight against V.D., are not the only community resource concerned with the eradication of these diseases. As in many other diseases the best treatment is prevention. This depends upon the public's awareness of the facts concerning the spread of venereal disease. Much can be and is being done by means of education through all the modern means of communication and publication including radio, television, newspapers, magazines and educational pamphlets.

Premarital and prenatal blood tests are other methods for detecting early

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- ☐ 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957.
- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

YOUR NAME AND ADDRESS

before Knox

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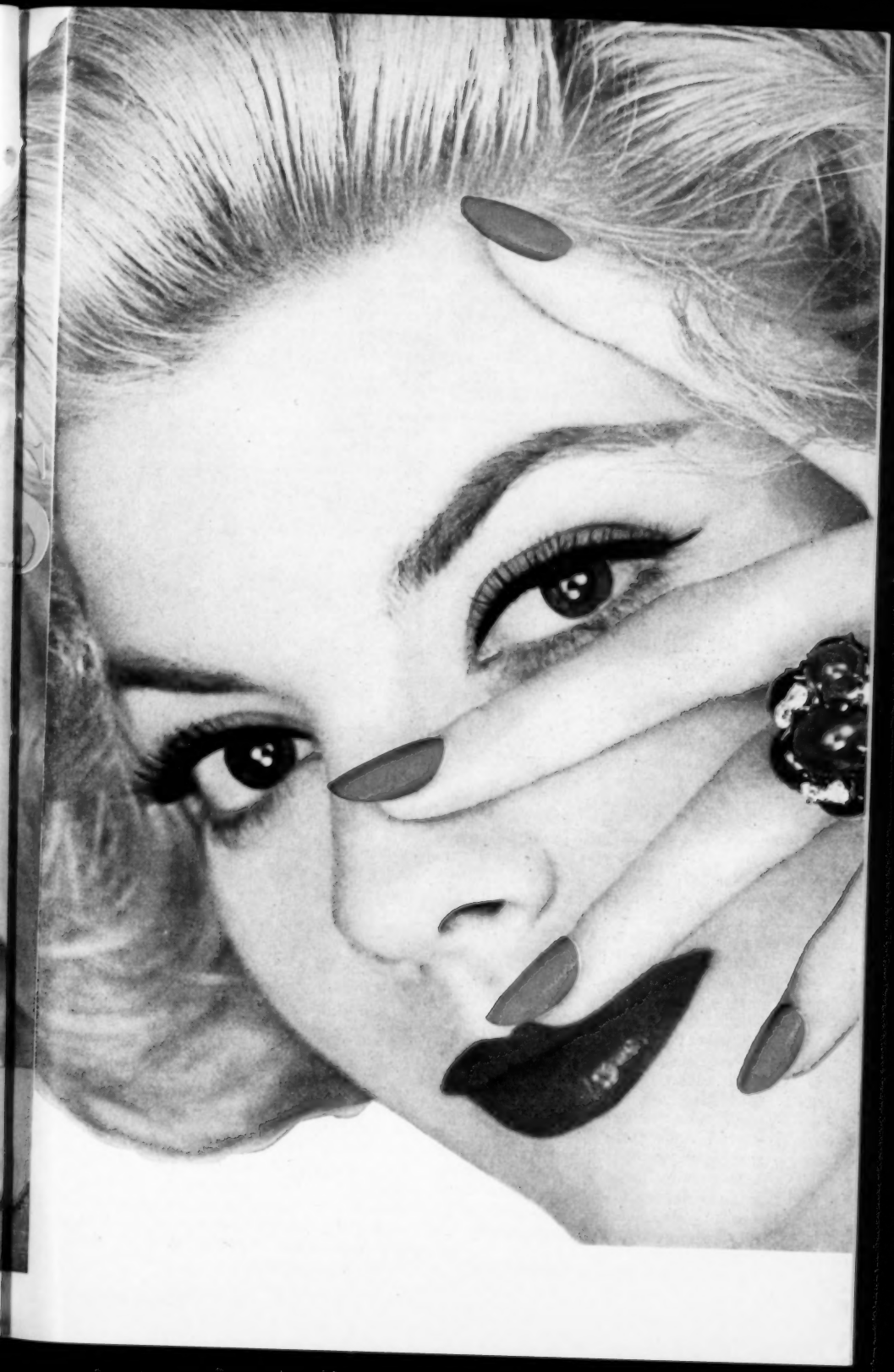

cases of syphilis. Only a small number of cases are actually found by these tests.

The administration of silver nitrate drops into the eyes of every newborn baby has largely reduced the incidence of gonorrheal ophthalmia neonatorum which now is encountered very rarely, though it used to be a major cause of blindness. Another problem to be taken into consideration is the environment in which those people live who largely make up the clientele of the V.D. clinic. It is one of the main aims of all those concerned with the control of these diseases to improve the environment whenever possible. Abolishment of houses of prostitution by legal measures as well as education in sex hygiene at schools would contribute greatly to reducing the incidence of these diseases.

The control of venereal diseases is a joint project where many participate in order to reach the goal of eventually eradicating them. It should be the responsibility of every educated citizen to join that campaign and to wholeheartedly contribute whatever is in his power. Nurses, whether they work in hospitals or in public health, have a responsibility to contribute their share in this program since they are more likely to come in contact with persons requiring care. Considering the devastating effects of late lues the nurse by observing signs and symptoms and by education of the public can contribute a great deal in either preventing these diseases or in ensuring early treatment which will save the community a valuable citizen and tax-payer and prevent the patient from becoming a burden to himself and others.

Medicine Man

JEAN WYATT

THE FIRST MEDICINAL prescription in Canada was compounded by a copperhued savage.

Jacques Cartier, early French explorer of this continent and discoverer of the mighty St. Lawrence River, with his party of men settled for the winter of 1535-36 in their ships in the frozen waters of this river at Quebec, then an Indian village. During their stay some of the men suffered severely from a strange illness unknown in France.

However, a friendly Indian told Cartier of the native remedy — boiled hemlock twigs and bark; the liquor to be drunk and the dregs used as a poultice for swelling and inflammation caused by the illness.

The diseases was scurvy which occurred among the Canadian Indians during winter months when storms and heavy snows made hunting and fishing impossible and when there was a shortage of dried corn, roots and herbs. Thus improper foods, especially an over-indulgence in salted meats, resulted in the outbreak of scurvy among Cartier's men.

The story of medicine in Canada then, properly began with the Indian who had remedies for every need — expectorants, emetics, purgatives, astringents, even emmenagogues. He was expert in his application of the medicinal properties of roots and herbs he collected.

For example the bark of the slippery elm and basswood and the resinous bark of the tamarack were applied to running sores. Ulcers responded to a treatment of the underbark and the juice of the juniper berry.

The redman was a skilled bonesetter who cleverly reduced and carefully set fractures of the bones. Splints of cedar were put on and padded by the squaws with leaves or grass. The limb was bound with the soft, pliable branches of the young birch. Dislocations were reduced by the simple application of force. Bruises were treated by the application of cold water in the form of a compress.

Mrs. Wyatt lives in London, Ont.

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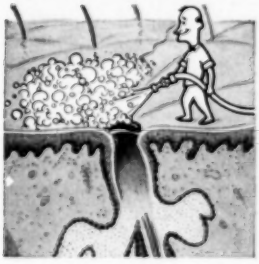
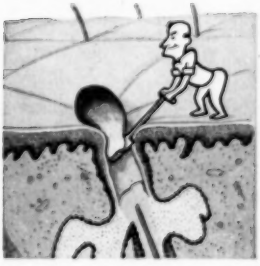


Fostex contains a combination of surface active agents (Sebulytic*) which:

◂ Completely emulsify excess oil so that it is quickly washed off the skin.



◂ Penetrate and soften comedones, unblocking the pores and facilitating removal of sebum plugs.

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Surgery was not a mystery to the Indian. He performed amputations at the joints with a knife of flint or jasper, then seared spouting vessels with stones heated to redness and thus arrested hemorrhage.

The Indian's system of medicine, surprisingly complete, was an unwritten one and one that was handed down from generation to generation. The care of the sick was placed in the hands of the women of the tribe who were thus the first nurses on this continent.

The Indian's diseases were those occasioned by the weather, hardship, famine, injury. Diseases of the eye were common due to prolonged irritation from the smoke in their lodges or teepees where a hole in the roof took the place of a chimney.

The arrival of the white man brought to the Indian new and unknown diseases that swept through his tribe like a devastating flame. Only then did his system of medicine break down.

Although the Indian population was severely decimated, today the medical marvels of the pale face have stemmed the tide and the Indian population is gradually increasing. Health services are administered by the Department of National Health and Welfare. In 1953, 20 hospitals, 42 nursing stations and 61 other health centres were operated by the Department to serve both the Indians and the Eskimos. Full-time departmental medical officers are assigned to the larger Indian reserves with part-time officers responsible for the health of the smaller bands.

A Silver Anniversary

THE UNIVERSITY of Toronto School of Nursing celebrated its 25th Anniversary with a very successful "Open House" at the School of Nursing, 50 St. George Street, on October 17, 18 and 19, 1958. Many alumnae and friends of the school took this opportunity to renew acquaintances and to tour the new building, opened in 1953.

One of the highlights of the celebration was the opening of regular classes to alumnae, high school students and the general public. These classes, from the basic and post-basic curricula, were of the lecture, seminar and demonstration types. Professor Margaret McPhedran and Miss Margaret MacLachlan lectured to the public health general students; Professor Jeannette Watson to the nursing education and nursing service groups, and Professor Muriel Uprichard gave a lecture on the problems of education. Professor Jean Wilson and Mrs. Carol Brehaut conducted nursing demonstration classes for the two junior years of the basic course. Miss Jeannetta MacPhail gave a lecture in obstetrics. Professors Mary Millman and Helen Carpenter conducted seminars with the fourth year basic students. Professor Millman's seminar included in its content a demonstration of using a tape recorder as a teaching method.

All of these classes were very well attended. A great deal of interest was shown by the high school students. Particularly well-received was a special "Symposium on Nursing Research" held in Cody Hall, the spacious auditorium of the school. Professor Nettie Fidler, director of the school, introduced the symposium. Professors Carpenter and Uprichard and Miss Margaret Allemang took part.

The focal point of the Open House consisted of 33 displays in Cody Hall, representative of the work and activities of the school and its 3450 graduates. The material in each display was both interesting and instructive and the general effect, aided by large flags of the countries represented, was quite impressive. A special feature which added considerably to the enjoyment of the guests was the provision by the alumnae association of refreshments for all.

Included among our many visitors were the following graduates of the various courses offered by the School: Misses Margaret McKenzie and Mary Pae, who are in India with WHO; Miss Gertrude Swaby, public health nursing in Jamaica; Miss Jamila Ahmed of Pakistan; Miss Alma Reid, director of the School of Nursing, McMaster University; Miss Ethel Gordon, Chief Supervisor of Nursing Counsellors of the Civil Health Services Division, Department of National Health and Welfare; Miss Heather McDonald, Nursing Consultant, Indian and Northern Health Services. Another welcome visitor was Miss Anne Moore, of the

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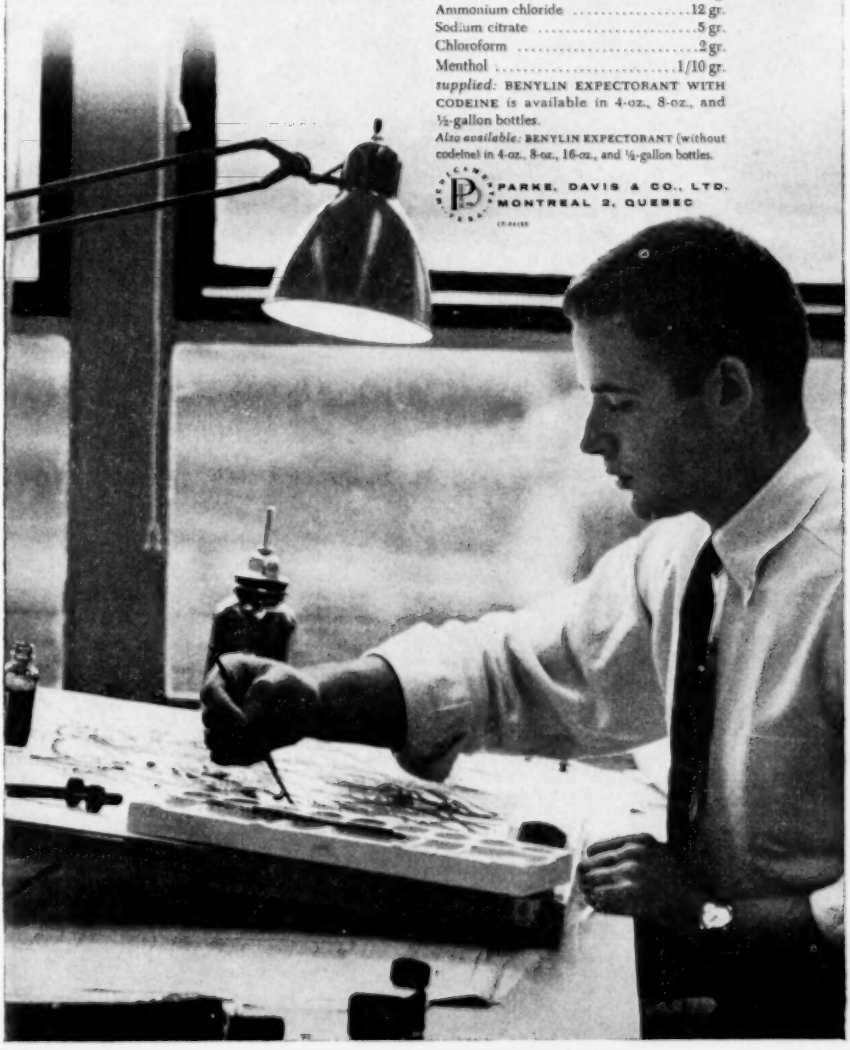

Colombo Plan Administration in Canada. Among our local visitors were the President and Vice-President of the University and many other members of the University staff. We were also delighted to welcome directors of nursing, staff members and students from hospital school of nursing and from public health agencies in Toronto.

Telegrams and congratulatory letters, many describing the work of the writers, were received with much appreciation. These came from as far away as Jugoslavia (Miss Dina Urbancic, Nursing Education 1949), Poland (Mrs. Jadwiga Izyeka Kaniewska, Nursing Education 1935), Denmark, (Miss Karen Jacobsen, Advanced Nursing 1940), Sweden (Miss Ruth Abrahamsen, Public Health Nursing Advanced 1953), Costa Rica (Miss Alicia Montealegre, Clinical Supervision 1954) and India (Mr. Jesudoss Sigamoney, Nursing Education 1955).

The tea given on Sunday afternoon by the alumnae association was the concluding event of the three-day celebration. It was attended by over 400 alumnae and friends. Miss Fidler and Miss Myrna Clark, president of the alumnae association, received the guests. Past presidents of the association acted as hostesses. Miss Kathleen Russell and Miss Florence Emory both attended and seemed to enjoy themselves thoroughly. A brief ceremony highlighted the tea when Miss Fidler, aided by one of our earliest graduates, Mrs. Josephine Clissold (Public Health Nursing 1923) and one of our most recent graduates, Miss Nancy Clark (B.Sc.N. 1958) took part in cutting the anniversary cake.

Strokes need not originate within the brain, as is commonly believed, and in many cases can be effectively treated through surgery outside the brain. In as many as one-fourth of those who suffer strokes, the brain's blood supply may be blocked by clots forming in vessels at points before they enter the brain itself. This circumstance makes it possible to remove or bypass the blockage and restore normal circulation to the brain. X-ray studies of arteries have shown that the obstruction is often located in an artery of the neck or upper torso. In such cases it may be possible to apply surgical procedures similar to those through which circulatory deficiencies in the arms, legs and elsewhere have been successfully treated.

— American Heart Association

1958 INDEX

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A Report of the I.L.O. Ad Hoc Committee

The CNA Nursing Secretary, **F. Lillian Campion** was invited by the International Labor Organization to represent Canada as a member of the Ad Hoc Committee on "Conditions of Work and Employment of Nurses." The meeting was held at the I.L.O. Headquarters in Geneva from October 6 to 11, 1958.

At the opening session, Miss Campion was named chairman and so had the privilege and responsibility of presiding over the week-long meeting.

Because of the interest in this significant international gathering, we are devoting this column to a summary report prepared by Miss Campion.

The I.L.O.

The I.L.O. is an agency of 70 governments united to work for lasting peace based on social justice. It deals with international labor and social problems, much as the UN Food and Agricultural Organization handles questions relating to the earth's food supply and the World Health Organization works to improve the health of the people living on this planet.

The I.L.O. is "tripartite." Each member country sends two government delegates, one employer and one worker to the I.L.O.'s Annual International Labor Conference.

The International Labor Office at Geneva, Switzerland is situated in a park on the banks of Lake Geneva, not far from the Palais des Nations. About 700 officials of 57 nationalities conduct a year round program of international action to raise living and working standards. They do the research and prepare the reports which are discussed at the I.L.O. conferences and meetings in all parts of the world.

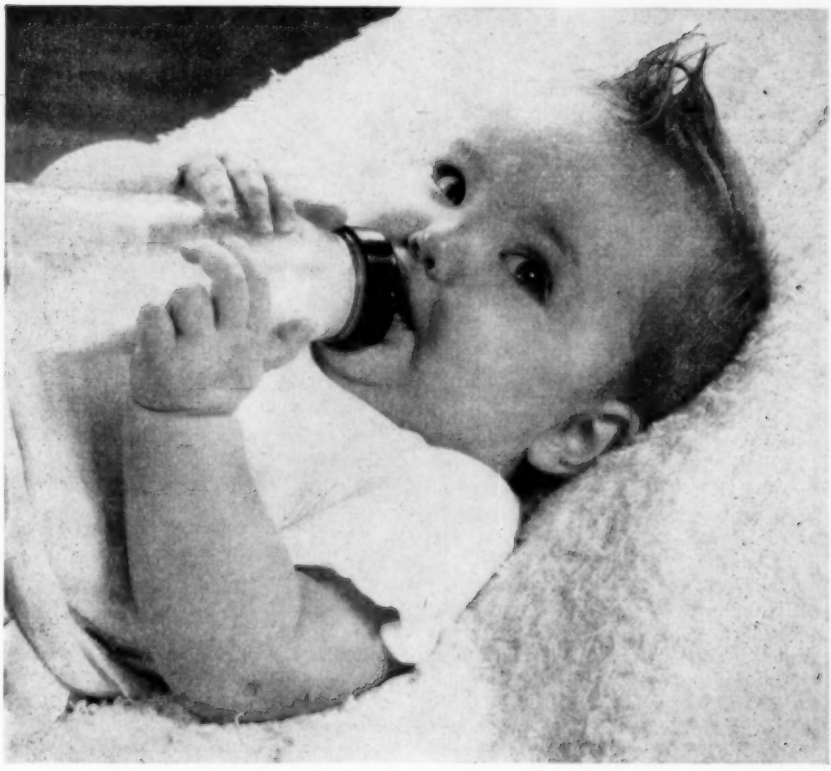
W.H.O. and I.L.O.

Some years ago, a W.H.O. Expert Committee on Nursing drew attention to the close link between the recruitment of candidates for nursing and the working and living conditions of nurses. They urged W.H.O. to invite the cooperation of I.L.O. in a joint investigation of the working conditions of nursing personnel including salaries, hours of work, health conditions and personnel policies. Other interested groups have since urged similar investigations.

Study of Conditions of Work

The Director General of the I.L.O. in 1957 arranged for a comparative study of the employment and conditions of work of nurses and agreed to convene an ad hoc meeting of experts to consider the results. The report of the study was the basis of the Committee's discussions. Miss Margrethe Kruse, Executive Secretary, Danish Council of Nurses and Chairman of the Committee on Exchange Privileges for Nurses, I.C.N., a professional nurse of wide experience, was appointed by the I.L.O. after consultation with W. H.O. to assist in the comparative study. The report was prepared on the basis of replies to a questionnaire circulated by the International Council of Nurses, the International Committee of Catholic Nurses and Social Workers, and the International Federation of Unions of Employees and Public and Civil Services to affiliated organizations in 67 countries.

He's happy! . . . he's on S - M - A!



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The material contained in the report, covering 54 countries in all parts of the world, as is stated in the introduction, necessarily conceals wide variations in political and economic and social backgrounds, traditions and conditions.

Ad Hoc Meeting

The meeting was opened by Luis Alvarado, Assistant Director-General of the I.L.O. who spoke on behalf of the Director-General, David A. Morse. Ambassador Julio A. Barboza-Carneiro of Brazil, Chairman of the Governing Body of the I.L.O. was also present at the opening meeting.

The study and the meeting were under the direction of the Women's and Young Workers' Division of the I.L.O. Mrs. Ana Figueroa, Chief, the Women's and Young Workers' Division was responsible for the vast amount of planning, organization and direction necessary for the comparative study and the Ad Hoc Committee meeting. This, together with her assistance during the deliberations, contributed greatly to the success of the meeting.

The members of the Committee represented 14 countries including Austria, Brazil, Canada, Chile, France, India, Japan, Liberia, Philippines, Sweden, Turkey, United Kingdom, U.S.S.R. and U.S.A. Mrs. Janet Buckle, President of the Liberian National Nurses' Association was elected vice-chairman and Miss Julita Sotejo, Dean of the School of Nurses, University of the Philippines, reporter.

Simultaneous translation was available in four languages, Spanish, German, French and English. The member from Russia was accompanied by a translator who translated into English as the delegate spoke.

Observers

In addition to the nurse members of the Committee, several inter-governmental and non-governmental organizations were represented by observers. Included were the World Health Organization, the Council of Europe, International Committee of Catholic Nurses, International Committee of the Red Cross, International Council of Nurses, the International Federation of Christian Trade Unions, Employees of Public Services and P.T.T.N., The International Federations of Unions of Employees of Public and Civil Service, the League of Red Cross Societies, the World Federation of Trade Unions and the World Medical Association. These observers had the privilege of speaking once to each of the four items on the agenda.

Topics of Discussion

The first four days were spent in discussion of the four items of the agenda which had been approved by the governing body of the I.L.O. These were:

Employment Situation —
Shortage of nurses; influence of marriage on employment; part-time employment.

Conditions of Work —
Contract of employment; remuneration; social security.

Economic and Social Status —
Professional nurses; auxiliary personnel.

Recruitment including counselling and placement services.

Recommendations

The very able Secretariat of the Division was invaluable in recording the discussions, abstracting the salient points and recommendations, preparing a draft report for the final consideration of the committee. Included in the recommendations were:

That more complete, reliable and detailed statistical information be collected as a basis for relating the supply of nurses to the demand for nursing services.

That the prevalent shortage of professional nurses, characteristic of most countries and acute in many, should be overcome by planned policies aimed at more effective utilization and retention of available nursing resources.

That in view of the importance of joint consultation in determining conditions of work, machinery for negotiating terms and conditions of employment should be set up in every country where it does not now exist. Nursing personnel, through organizations of their choice, should be associated directly in its operation.

That in order to meet the special re-

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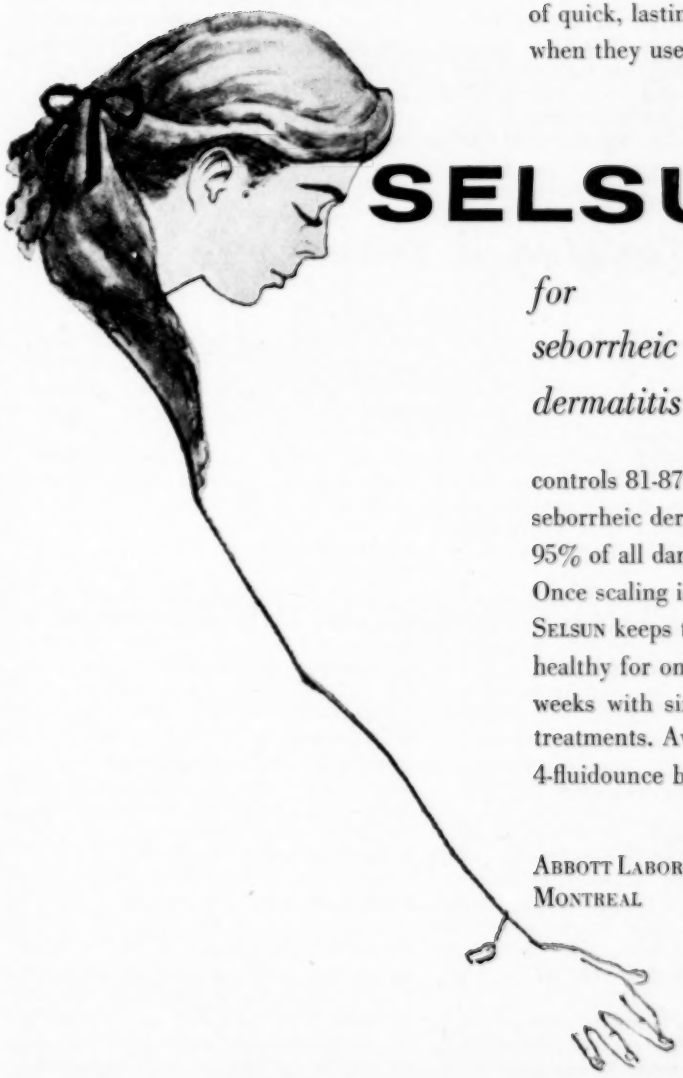

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quirements of nursing service, and to avoid fatigue for nursing personnel, hours of work should not exceed an average of 40 per week, that strict limits should be placed on the working of overtime within any given work period and that weekly rest should be uninterrupted and should be not less than 36 consecutive hours.

That remuneration for nursing personnel, should be raised to a level commensurate with their education, qualifications, responsibilities and duties. Salary scales should be calculated on the basis of job analysis and evaluation and the principle of equal remuneration for men and women for work of equal value should be adopted.

That adequate opportunities should be provided for professional development and advancement through such measures as specialized post-basic education, study and fellowships, security of tenure and safeguard of privileges on transfer.

That recruitment programs should be planned on a long-term basis in relation to the demand for nursing service and skills and should be based on facts regarding conditions and needs of all branches of the nursing service.

Le Nursing à travers le pays

Rapport d'un Comité spécial de l'O.I.T.

La secrétaire de la Section du Nursing, Mlle **F. Lillian Campion**, fut invitée par l'Organisation Internationale du Travail à représenter le Canada auprès du Comité spécialement formé pour étudier "les conditions de travail et d'emploi chez les infirmières." La réunion eut lieu aux quartiers généraux de l'O.I.T., à Genève, du 6 au 11 octobre 1958.

A la séance d'ouverture, Mlle Campion fut nommée présidente, honneur qui lui donna le privilège et la responsabilité de présider les assises durant une semaine.

Vu l'importance de cette réunion internationale, toute cette chronique sera consacrée au rapport préparé par Mlle Campion.

L'Organisation Internationale du Travail

L'O.I.T. comprend 70 pays unis pour travailler à l'obtention d'une paix durable, basée sur la justice sociale. C'est un organisme qui s'occupe des questions de travail et des problèmes sociaux tout comme l'Organisation Mondiale de la Santé s'occupe de l'amélioration de la santé des habitants de cette planète.

L'O.I.T. est "tripartite." Chaque pays membre y est représenté par deux délégués de son gouvernement, un employeur et un travailleur, à la Conférence Annuelle de l'O.I.T.

Le Bureau à Genève, Suisse, est situé dans un parc sur les bords du lac Genève, non loin du Palais des Nations. Environ 700 personnes de 57 nationalités y travaillent de façon permanente à la réalisation d'un programme de portée internationale visant à élever le niveau de vie et de travail. On y fait de la recherche et l'on rédige des rapports qui sont discutés au cours des conférences et réunions de l'O.I.T. dans toutes les parties du monde.

L'O.M.S. et l'O.I.T.

Il y a quelques années, un Comité d'experts en Nursing de l'O.M.S. attira l'attention sur la relation étroite qui existe entre le recrutement des candidates infirmières et les conditions de vie des infirmières. Le Comité insista pour que l'O.M.S. sollicite la collaboration de l'O.I.T. dans une étude conjointe des conditions de travail chez les infirmières: salaires, heures de travail, conditions sanitaires, lignes de conduite, etc. Depuis ce temps d'autres groupes firent la même demande.

Etude sur les conditions de travail

Le directeur général de l'O.I.T. prépara une étude comparative sur les conditions d'emploi et de travail chez les infirmières et décida d'en soumettre les résultats à un comité *ad hoc* d'experts qui en étudia et en discuta le rapport. Mlle **Margrethe Kruse**, secrétaire du Conseil des Infirmières du Danemark et présidente du Comité d'Echange entre membres du C.I.I., fut choisie par l'O.I.T., après consultation avec l'O.M.S., pour collaborer à cette étude com-

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parative. Le rapport de cette étude a été rédigé d'après les réponses à un questionnaire envoyé par l'intermédiaire du Conseil International des Infirmières, du Comité International des Infirmières catholiques et des Travailleurs sociaux et de la Fédération Internationale des Unions d'employés ainsi que des Services publics et civils, à des organisations connexes dans 67 pays.

Le matériel de ce rapport couvrant 54 pays de toutes les parties du monde révéla une grande variété dans les idées politiques, économiques et sociales dans les traditions et les conditions de vie et de travail.

Assemblée ad hoc

L'assemblée fut ouverte par Luis Alvarado, directeur-général adjoint de l'O.I.T. qui parla au nom du directeur-général, David A. Morse. L'ambassadeur Julio A. Barboza-Carneiro du Brésil, président du Bureau de direction de l'O.I.T. était aussi présent à la séance d'ouverture.

L'étude et l'assemblée étaient sous la direction de la Division des Femmes et Jeunes Travailleurs de l'O.I.T. C'est Mme **Ana Figueroa**, chef de cette division qui assuma la vaste tâche de l'organisation et de la direction de l'étude comparative et du comité spécial. Ce travail et sa présence aux débats contribuèrent grandement au succès de cette réunion.

Les membres du Comité représentaient 14 pays: l'Autriche, le Brésil, le Canada, le Chili, la France, l'Inde, le Japon, le Libéria, les Philippines, la Suède, la Turquie, le Royaume-Uni, l'U.R.S.S. et les Etats-Unis. Mme Janet Buckle, présidente de l'Association nationale des Infirmières du Libéria, fut élue vice-présidente et Mlle Julita Sotejo, Principale de l'Ecole d'Infirmières de l'Université des Philippines, fut nommée rapporteur.

La traduction simultanée fut faite en quatre langues: l'espagnol, l'allemand, le français et l'anglais. La représentante de la Russie était accompagnée d'un traducteur qui traduisait en anglais ce qu'elle disait en russe.

Observateurs

En plus des infirmières membres du Comité, plusieurs organismes gouvernementaux et autres étaient représentés par des observateurs. Etaient ainsi représentés: l'Organisation Mondiale de la Santé, le Conseil d'Europe, le Comité International des Infirmières Catholiques, le Comité International de la Croix-Rouge, le Conseil International des Infirmières, la Fédération Internationale des Unions Ouvrières Chrétiennes, les Employés de Services Publics et P.T.T.N., la Fédération Internationale des Unions d'employés de services publics et civils, la Ligue des Sociétés de la Coix-Rouge, la Fédération Mondiale des Unions Ouvrières et l'Association médicale Mondiale. Ces observateurs eurent le privilège de parler une fois sur chacun des quatre sujets au programme.

Sujets de la discussion

Les quatre premiers jours furent consacrés à la discussion des quatre questions inscrites à l'ordre du jour, préalablement approuvés par le Bureau de direction de l'O.I.T., savoir:

Situation de l'emploi — Pénurie d'infirmières; influence du mariage sur l'emploi; le travail à temps partiel.

Conditions de travail — Contrat d'emploi; rémunération, sécurité sociale.

Statut social et économique — Infirmières professionnelles, personnel auxiliaire.

Recrutement comprenant services d'orientation et de placement.

Recommandations

Le personnel du secrétariat de la Division a pris les délibérations avec toute la compétence qui le caractérise, a fait un résumé des points saillants des recommandations et a rédigé un rapport final pour être soumis au Comité. Parmi ces recommandations nous notons les suivantes:

Que des renseignements statistiques plus complets, plus sûrs et plus détaillés soient compilés pour servir de base à l'établissement de comparaisons entre l'offre et la demande des services d'infirmières.

Que l'on remédie à la pénurie d'infirmières professionnelles existant dans la plupart des pays et à l'état aigu dans plusieurs, par l'établissement d'une ligne de conduite visant une utilisation plus efficace ainsi qu'à la conservation des ressources disponibles dans le domaine du nursing.

Qu'en vue de l'importance d'une consultation mutuelle dans la détermination des conditions du travail, un organisme servant à déterminer les conditions d'emploi et les traitements devrait être établi dans les pays où cela n'existe pas. Les infirmières, par l'intermédiaire d'organisations de leur choix, devraient être directement associés à son fonctionnement.

Qu'afin de répondre aux exigences particulières du soin des malades et d'éviter la fatigue chez les membres du personnel soignant, les heures de travail devraient être fixées de façon que les heures supplémen-

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taires de travail soient judicieusement réparties et que le repos hebdomadaire ne soit pas interrompu pendant au moins 36 heures.

Que la rémunération des infirmières soit proportionnée à leur instruction, leur préparation, leurs responsabilités et leurs fonctions. La barème des salaires doit être calculé en se basant sur l'analyse et l'évaluation des tâches, en respectant le principe du salaire égal à travail égal, pour les hommes et les femmes.

Que l'on favorise le développement et l'avancement de la profession par l'établissement de cours post-scolaires, études, bourses, assurance de la stabilité de l'emploi et transfert des privilèges acquis lorsqu'une infirmière change d'employeur.

Que les programmes de recrutement soient à longue portée, tenant compte de la demande, et basés sur des faits établis selon les besoins et les conditions de toutes les différentes branches du nursing.

Victorian Order of Nurses

The following is a list of recent staff changes in the Victorian Order of Nurses for Canada.

Appointments — *Theresa Bergeron* (St. Vincent de Paul Hosp., Sherbrooke, P.Q.) to Edmunston, N.B. *Mary Bradley* (Univ. of Ottawa) to Bathurst, N.B. *Barbara Brannan* (Saint John Gen. Hosp.) to Saint John. *Shelby Bouthiller* (Misericordia Gen. Hosp. Winnipeg) to Winnipeg. *Patricia Cave* (Grace Hosp., Windsor) to Windsor. *Mavis Chittick* (Yale Univ. S. of N., New Haven) to Calgary. *Beverley Copithorne* (Vancouver Gen. Hosp.) to Vancouver. Mrs. *Olga Coyes* (Saskatoon City Hosp.) to Edmonton. *Judith F. Davis* (Royal Jubilee Hosp., Victoria) to Montreal. *Joyce Dickey* (Vic. Hosp., London) to Digby, N.S. *Audrey Drennan* (Mack Training School for Nurses, St. Catharines) to Owen Sound. *Susan Geml* (Hotel Dieu, Windsor) to Windsor. *Ruther Mary Gwilliam* (Hope Hosp., Salford, Lancashire) to Greater Montreal. *Emilia Hagel* (St. Michael's Hosp., Lethbridge) to Carleton Place, Ont. *Ruth Hayden* (Univ. of B.C.) to Halifax. *Ruby Henrickson* (Winnipeg Gen. Hosp.) to Winnipeg. *Merilyn Ethel Hood* (Vic. Hosp., London) to Montreal. *Elizabeth Anne Hutchinson* (V.G.H.) to Victoria. *Carol Irvine* (Hamilton Gen. Hosp.) to London. *Esther Janzow* (Royal Columbian Hosp. New Westminster) to Victoria. *Georgina Johnson* (Grace Hosp., Winnipeg) to Winnipeg. *Patricia Ann Lauerner* (U.B.C.) to Vancouver. *Olive Legge* (Moose Jaw Union Hosp.) to Vancouver. *Donna McDougall* (Kingston Gen. Hosp.) to Smiths Falls. Mrs. *Mary McEvoy* (Royal Vic. Hosp., Montreal) to Montreal. Mrs. *Beverly McIntyre* (Univ. of Toronto S. of N.) to Toronto. Mrs. *Barbara Ann McWilliams* (V.G.H.) to Vancouver. *Halley Anne MacBain* (H.G.H.) to Hamilton. *Patricia Ann Madley* (U.B.C.) to Vancouver. *Mary Patricia Malloy* (V.G.H.) to Vancouver. *Sheila Meiteen* (Jewish Gen. Hosp., Montreal) to York Township. *Gwendolyn Miller* (Metropolitan Hosp., Windsor) to Cobalt-Coleman. *Barbara Mills* (Moncton Hosp., N.B.) to Moncton. *Sheila Murray* (V.G.H.) to Wolfville, N.S. *Janet Penney* (Grace Hosp., Halifax) to Pictou, N.S. *Katie Peters* (V.G.H.) to Trail, B.C. *Dorothy Philips* (Montreal Gen. Hosp.) to Arnprior. *Noreen Phillpot* (MacMaster Univ. S. of N.) to Burlington, Ont. Mrs. *Gaye Donna Pilling* (MacMaster Univ. S. of N.) to Montreal. Mrs. *Cynthia Powell* (V.G.H.) to Winnipeg. *Shirley Receveur* (Holy Family Hosp., Prince Albert) to Prince Albert. Mrs. *Mary Richardson* (Victoria Hosp., London) to Toronto. *Elaine Marina Rose* (Toronto Gen. Hosp.) to Guelph. Mrs. *Gaye Ross* (V.G.H.) to Burnaby. *Olga Smuczok* (Grace Hosp., Windsor) to Windsor. Mrs. *Gloria Tufford* (Moose Jaw Union Hosp.) to Ottawa. *Maria Vandenijssel* (Vronstein Park Vronsteil, Voorburg, Holland) to Montreal. *Myra Ellen Warren* (Calgary Gen. Hosp.) to Greater Niagara. *Mary Dawn Webster* McMaster Univ. S. of N.) to Hamilton. *Gertrude Woelders* (Diaconessenhuis, Haale, Holland) to Halifax.

Transfers — *Lola Bott*, Mrs. *Alma Metcalfe* to Montreal. *Patricia Copley* to North Vancouver. *Donna Hackman* to Prince Albert. *Beatrice M. Hunt* to Ottawa. *Winnifred James* to North York. *Marie Kossowka* to LaSalle, P.Q. *Ada McEwen, Ethel Shaw*, to National Office. *Elizabeth MacKenzie* to Saint John, N.B. *F. Blanche MacPherson* to St. John's, Nfld. *May Louise Shaffner, Elizabeth Smith* to Vancouver. *Margaret Standerwick* to Lethbridge. *Maria Van Noort* to Edmonton. *Margaret Warren* to Sarnia. *Lily Watanabe* to York Township.

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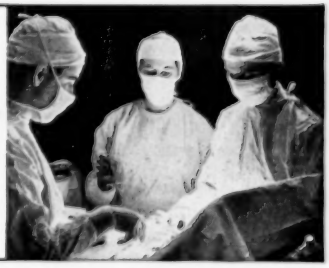

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International Essay Competition

The International Council of Nurses, through its Ethics of Nursing Committee, announces an international essay competition in which **Graduate Nurses** of all national member associations in membership with the ICN are invited to take part.

The competition is designed to reach individual members in the nursing field and to increase their awareness of the meaning and significance of nursing ethics.

For more than half a century, at the closing session of each International Congress, the retiring President has given a "Watchword" for the next four-year period. This has become a valued tradition for as one President, the late Baroness Sophie Mannerheim, has said: "Words are not always solely words. Sometimes a word can be engraved on our hearts and be as a guide for our work."

The **subject** of the essay is to be either:

1. One of the watchwords given by an ICN President, or

2. The *International Code of Nursing Ethics,* how it could be brought into nursing schools and ways and means of integrating teaching so that ethics may be included in all nursing subjects.

The **watchwords** are as follows:

1901—Buffalo—Mrs. E. Bedford Fenwick —*Work*
1904—Berlin—Mrs. E. Bedford Fenwick —*Courage*
1909—London—Mrs. E. Bedford Fenwick —*Life*
1912—Cologne—Schwester Agnes Karll —*Aspiration*
1925—Helsinki—Baroness Sophie Mannerheim—*Peace*
1933—Paris, Brussels— Mlle L. Chaptal —*Concord*
1937—London—Dame Alicia Lloyd Still —*Loyalty*
1947—Atlantic City—Miss Effie Taylor —*Faith*
1953—Petropolis—Miss Gerda Höjer —*Responsibility*
1957—Rome—Mlle Marie M. Bihet —*Wisdom*

Conditions of Entry

1. The competition is open to graduate nurses who are members of ICN member associations. If any question arises as to the eligibility of a contributor, the decision of the panel of judges shall be final.

2. The Essay shall be typewritten on one side of the paper only and shall be approximately 2,000 to 3,000 words.

3. Each entry must be signed by a "pen-name." The name and address of the contributor must be enclosed in a sealed envelope and attached to the manuscript.

4. The essay must be forwarded to the national Nurses' Association of the country concerned.

5. National Nurses' Associations have kindly undertaken to assist the Ethics of Nursing Committee in the following ways:
   (a) To receive completed essays.
   (b) To judge essays nationally by a National judges' panel.
   (c) To translate the winning essays into English (if necessary) and forward them to the Headquarters of the International Council of Nurses.

The closing date for Canadian entries will be **May 15, 1959.**

National Nurses' Associations will forward not later than September 1,1959, five copies of each of the two winning essays on a Watchword or the International Code of Nursing Ethics, or if one subject only has been selected, five copies of the winning essay only.

6. A prize will be awarded for the winning essay (in each of the two subjects if both are selected by the National Associations). Credit will be given in the case of those essays which give evidence of a knowledge and appreciation of fundamental ethical principles.

7. The winning essays will be published in *The International Nursing Review.* No entry may be sent which has previously appeared in print.

8. No essay submitted may be published in any nursing journal or in any other form without the permission of the International Council of Nurses. Essays will be returned to the writers after the results of the competition have been announced. For this purpose a self-addressed envelope should be enclosed with the original material, and the cost of postage refunded.

9. The International Judges' Panel will consist of five members: —

The General Secretary, ICN.

The Editor, *The International Nursing Review.*

The chairman and two other members of the Ethics of Nursing Committee.

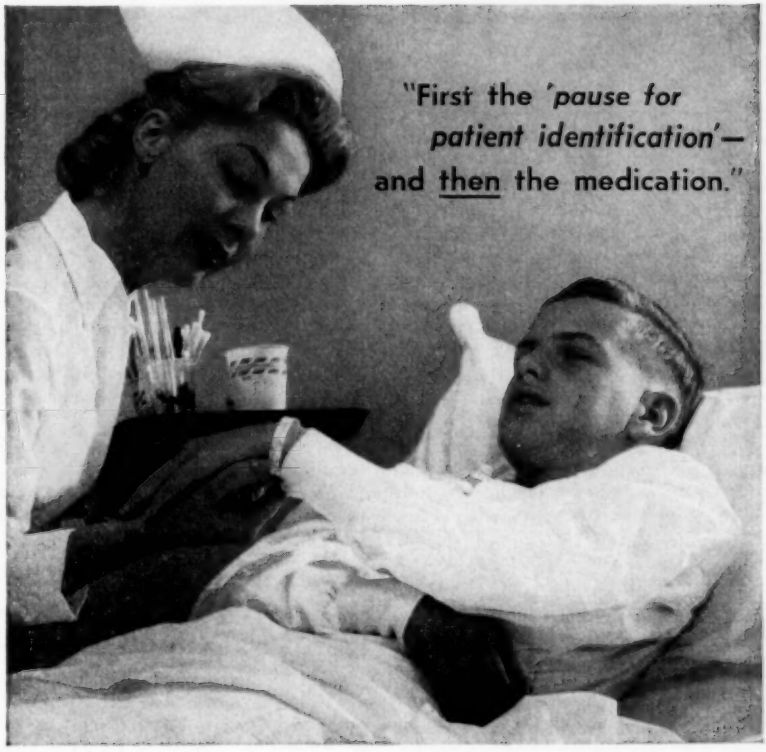
The antibiotic drugs and the development of the powerful new operating microscopes have enabled the ear surgeon to safely perform operations on delicate middle ear structures, previously impossible. They have also helped us to find out a great deal more of the effect of middle ear disease on hearing so that attention has been directed to the developing of new operations to restore damaged hearing function. This has opened up a whole new field in ear surgery and promises great benefit to all those who are suffering from middle ear deafness.

— G. Alexander Fee, M.D.

* * *

Blessed are the forgetful; for they get the better even of their blunders.

— Friedrich Wilhelm Nietzsche



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Ontario

The following is the list of changes in the Ontario Public Health Services.

Appointments — *Olga Roman* (Royal Vic. Hosp., Montreal, Univ. of Toronto) and *Dorothy Lee Chisholm* (R.V.H., Montreal, McGill Univ.) to Belleville Board of Health. *Ruth Tackaberry* (Western Hosp., Toronto, Univ. of West. Ont.), *Gwendolyn A. Hudson* (Ottawa Civic Hosp., U.W.O.) and *Margaret Farrell* (St. Jos. Hosp., London, U.W.O.) to Elgin-St. Thomas Health Unit. *Alda G. Ruthven* (Guelph Gen. Hosp., U. of T.), *Mary-Ellen MacDonald* (St. Mary's Hosp., Timmins, U. of T.), *Susie Elizabeth Beck* (Hosp. for Sick Children, Toronto, McGill Univ.) to Elliot Lake Improvement District, Ont. *Barbara Ross Fleming* (H.S.C., Toronto, McGill Univ.) and *Pauline Tomlin* (Victoria Hosp., London, U.W.O.) to Etobicoke B.H. *Marilyn (Deamude) Hunter* (T.G.H., Ont. Hosp., Queen's Univ.) to Fort William H.U. *Mary Georgina (Scroggins) Stever* (Vic. Hosp., London, U. of T.) to Galt B.H. *Ruth Moyer* (T.G.H., U. of T.) to Guelph B.H. *Bertha Reid* (R.V.H., Montreal, McGill Univ., U. of T.), *Norma E. O'Shea* (St. Jos. Hosp., Kingston, Univ. of Ottawa), *Ethel Hounslow* (Brantford Gen. Hosp., U. of T.) to Halton Co. H.U. *Laura Bowen* (Kingston Gen. Hosp., U. of T.) to Kingston B.H. *Mary Burns* (St. Jos. Hosp., London, U.W.O.) to Lambton H.U. *Joan Marie (Cormack) Gibson* (H.S.C., Toronto, U. of T.) to Muskoka H.U. *Marion (Johnston-Dickson) Rankin* (T.G.H., U. of T.) to Northumberland and Durham H.U. *Henrietta (LaRocque) Findlay* (Ottawa Gen. Hosp., Univ of Ottawa), *Ruth Henry* (Brockville Gen. Hosp., U. of T.), *Mary S. (McCulloch) Bannerman* (T. G.H., McGill Univ.), *Barbara Ann Gallivan* (St. Michael's Hosp., U. of T.) and *Barbara M. McMath* (U. of T.) to Peel Co. H.U. *Joan Dietrich* (K.G.H., U.W.O.), *Shirley Harding* and *Lorna Harris* (Montreal Gen. Hosp., U. of T.), *Jewel Killorin* (Grey Nun's Hosp., Regina, U. of T.), *Barbara (Mackay) Miller* (Dalhousie Univ.), *Jane O'Loughlin* (St. Jos. Hosp., Peterborough, U.W.O.) to Peterborough B.H. *Lorna Nelson* (General & Marine Hosp., Owen Sound, U. of T.), *Margaret Goodes* (Hamilton Gen. Hosp., U. of T.), *Grace (Smith) Kirkpatrick* (H.G.H., U.W.O.) and *Noreen McQueen* (Hotel Dieu Hosp., Moncton, N. B., Dalhousie Univ.) to St. Catharines-Lincoln H.U. *Dorothy Gibson* (St. Jos. Hosp., Hamilton, U. of T.) and *Joan Royle* (McMaster Univ.) to Sault Ste Marie B.H. *Joyce Elizabeth Longbottom* (St. Jos. Hosp., Toronto, U. of T.) to Scarborough Board of Health. *Ann P. Blair* (Wellesley Hosp., U. of T.) and *Norah Bradley* (St. Michael's Hosp., Univ. of Ottawa) to Stormont-Dundas and Glengarry H.U. *Helen (Epstein) Ghent* (McMaster Univ.), *Marleen (Laine) Pentilla* (Sudbury Gen. Hosp., U. of T.), *Lucille Thibault* (St. Jos. Hosp., Three Rivers, Que. Univ. of Montreal) to Sudbury and District H.U. *Grace O'Leary* (St. Jos. Hosp., Sudbury, Univ. of Ottawa) to Sudbury Gen. Hosp., *Jean E. Humphrey* (T.G. H., U. of T.) to Timiskaming H.U. *Elizabeth J. P. Davidson* (Toronto East Gen. Hosp., U. of T.), *Barbara Ann (Goddard) Pinchin* (Victoria Hosp., London, U.W.O.) to Waterloo Township B.H. *Mary Ann Ladesick* (St. Jos. Hosp., Kingston, Univ. of Ottawa) to Wentworth Co. H.U. *Esther V. Matheson* (Oshawa Gen. Hosp., U.W.O.) to Widdifield B.H. *Frances G. Hincks* (Hamilton Gen. Hosp., U. of T.) to Weston B.H.

Resignations — *Elizabeth Zadanyi* and *Sara Ann (Lambert) Sibay* from Haldimand School Health Service. *Lynn (Dobbin) Spencer* and *Anne (Allen) Beckwith* from York Co. H.U. *Doreen (Mainse) Appleton* from Lennox and Addington H.U. *Alice May Lake* from Muskoka H.U. *Janet (Thomson) Reed* from Huron Co. H. U. *Emilienne Dion, Suzanne Tambeau* and *Alli (Huhta) Schatz* from Porcupine H.U. *Yvette Muir* from Wellington Co. H.U. *Hazel Thompson* from Waterloo Township B.H. *Goldie Allen* and *Jean Ann McWhirter* from Oshawa B.H. *Glenna (Mowat) Craig* and *Barbara Jean Nelson* from Norfolk Co. H.U. *Doreen Noonan* from Deep River Improvement Dist. *Joan Willson* and *Kathleen Barry* from St. Catharines-Lincoln H.U. *Jean (Rorke) Gilliard* from Timiskaming

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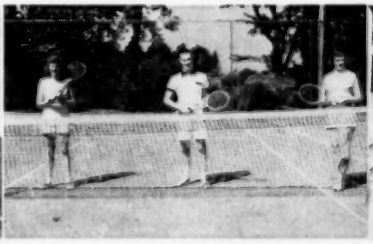

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Retirements — *F. Farr* from York Co. H.U. *W. Ashplant* from Secondary School Health Services, Board of Education, London. *M. Fawcett* from B.H., Hamilton. *M. Daley* from Ottawa B.H.

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by half a million every week — more than the total of the present populations of Halifax, Quebec, Hamilton and Victoria.

News Notes

ALBERTA

Furnishing the new provincial office building has become a matter of interest to the chapters of the A.A.R.N. Members of the Taber group recently donated $10 while High River nurses debated the question of assisting with this project and increasing their membership. There were nine members present at a recent meeting. The Peace River chapter is investigating the possibility of joining with the Grande Prairie unit for a joint social or business meeting. In addition this chapter is also considering the matter of establishing Emergency Housekeeping Services and teaching home nursing. Jasper's Edith Cavell chapter has contributed to the provincial office fund and made arrangements for a course in First Aid for its members. It is also hoped that a part time public health nurse will be obtained for the community. In Hanna, each member donated $1 towards furnishing the new building.

Vulcan has decided to continue as a chapter with regular monthly meetings being held at the homes of the members. A gift of $15 was forwarded to the provincial office fund. Several members from the Wainwright branch were present at the official opening of the new office building. The Banff chapter donated an electric tea kettle to the Nurses' Residence and a fund has been started to purchase a television set. Yearly membership dues were increased to $2.

District 2

Ponoka

A gift of $100 was sent to provincial office to help pay for furnishings in the new building. Latest figures show that the chapter has a total of 47 active members. A committee arranged for a dance and supper party in November as a means of raising funds.

Members were asked to consider their organization in the light of its value to the community. It was felt that there should be a definite program of activities and a specific aim. Several suggestions were made and a committee organized to investigate the question of presenting bursaries. Mrs. Margaret Newfeldt was a special guest speaker on one occasion. She gave a report on the first convention held by the Alberta Certified Nursing Aide Association.

District 3

Calgary

Forty members attended the supper party and annual chapter meeting held at the Holy Cross Hospital. Mrs. Duthie gave a brief and entertaining report of her attendance at the CNA general meeting and presented a scrapbook of clippings as a memento. The treasurer's report included mention of a bursary presented during the summer to Carol Osborne, a prospective C.G.H. student. Miss Walton-Jones, a visitor from St. George's Hospital, London, Eng. outlined her tour of American and Canadian hospitals briefly. Miss M. Street spoke about the building program at C.G.H. and the furnishings required. An objective of $700 was set to be contributed by the chapter for furnishing the lounge.

The new officers for this season are: Pres., Mrs. M. Duthie; Vice-Pres., J. Cummins; Sec., D. Green; Treas., L. McComb; Committees: Institutional, L. Bibby; Public Health, G. Broad; Private nursing, Mrs. J. Harrison; Program, D. Watrin, K. McLeod; Refreshments, Miss Brown, C. Chukaluk; Public Relations, F. Moore.

District 4

Medicine Hat

R. Ziehran and D. Schafer described their experiences as delegates to the CNA convention at one of the fall meetings of the chapter. They illustrated their report with slides, much to the enjoyment of the 22 members present. Miss Ziehran was the convener of the Harvest Tea held during the early fall. Inactive nurses are showing a lively interest in the refresher course planned for them. R. Ziehran has consented to teach home nursing to the St. John's Ambulance group.

District 6

Red Deer

It was reported at a recent chapter meeting that 11 applications had been forwarded to the Bursary Committee — six of the applicants being eligible. The lucky recipient was Pamela Bower and the bursary was presented to her at a dinner attended by 18 members. Mmes Forbes and Sirois are conveners for a bake sale to be held as a fund raising project. Everyone was pleased to learn that meeting rooms are available at the Memorial Centre.

District 7

Athabaska

Chapter meetings are under way again for the remainder of the year and although the group is small, it is enthusiastic. During the summer the members supplied First Aid kits at three points on the local lakes and were gratified to find that they were used and appreciated.

If enough applicants turn up, the Auxiliary of the local hospital plans to sponsor a home nursing course. Chapter members have offered their assistance. They have also helped the Civil Defence organization to arrange for a demonstration in the care of casualties.

Jasper

Mrs. J. Nordgren has been elected president of the Edith Cavell chapter for the remainder of its present fiscal year. Eleven members were present at a meeting held at the home of Mrs. P. Pohlman.

A letter from Mrs. Van Dusen described the new provincial office and expressed the hope that the chapter would assist in furnishing it. A set of baby scales was donated to the hospital by Mrs. Bruce on behalf of the chapter.

District 8

Lethbridge

Sister Beatrice and Miss D. Watson reported on their trip to Ottawa as CNA convention delegates at an early fall meeting. Sister Beatrice also presented a detailed summary of the Canadian Conference on Nursing held in Ottawa in 1957. A Civil Defence course was held during late September and received the interested support of chapter members.

Taber

Miss Alice Reti who entered Lethbridge Municipal Hospital last September was presented with a cheque for $50 at the Bursary Tea held by the chapter members during the same month. A display booth at the Family Fair in November was used to good advantage to interest young women of the area in nursing. Mrs. Vicol and Mrs. Malo were in charge of it.

A telephone bridge and whist party has been planned. The following committee chairmen were appointed: Activities, Mrs. D. Enman; Membership, Mrs. B. Rash; Finance, Betty Carnahan; Program, Mrs. B. Gibbings; Lunch, Mrs. D. Dick.

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BRITISH COLUMBIA

COURTENAY

Thirty-two members attended a meeting of the Plateau Chapter held in St. Joseph's Hospital, Comox last fall. Three religious sisters from Ontario were welcomed into the membership and a public health nurse from England was a visitor. G. McQuinn attended the institute for operating room nurses held in Vancouver. Several members represented the chapter at the district meeting held at Lake Cowichan. Assistance was provided for the Red Cross Blood Donor Clinic by addressing appointment cards and helping on clinic day. G. Skinner was elected to be in charge of the Future Nurses' Club for local high school students. She hopes to arrange a regular program to create interest in nursing as a profession. Mrs. W. K. Hind attended a Council meeting in Vancouver recently.

VANCOUVER

St. Paul's Hospital

A. T. Scullion has been awarded the Vancouver District bursary for use in postgraduate education. C. Terry, a graduate of last year, is working with the Indian Health Department. N. Rumen of the R.C.A.M.C. has been doing postgraduate study at the Royal Victorian Montreal Maternity Hospital. K. Dufton, C. Quan, M. Hildebrant, N. Martens and A. Klassen are at U.B.C. this year. D. Ritchie and H. Hull completed requirement for their certificates in teaching and supervision from the same university.

More than 150 operating room nurses attended an institute sponsored by the Registered Nurses' Association — the first of its kind in this province. Miss G. McFayden, supervisor of operating rooms, Shaughnessy Hospital directed the institute. Physicians and nurses from Vancouver and Victoria lectured and demonstrated. Miss E. Prickett, assistant professor, University of Pittsburgh and consultant in operating room nursing to the National League for Nursing, New York, also participated.

Sister Ann Emily has been appointed Superior at North Battleford. Helen McLean ('52) has joined the staff of Huntingdon Memorial Hospital, Pasadena. L. (Logan) Hill is working as a doctor's' office nurse in Cocoa Beach, Florida. Ann Colson ('57) has enrolled at the University of Manitoba in public health nursing.

The annual alumnae dance is to be held at the Commodore this spring and will be shared with the members of the graduating class. A fashion show replaced the usual fall bazaar last year and members enjoyed the new styles displayed by a local dress shop. A sale of home cooking, candy and miscellaneous articles helped to increase profits.

MANITOBA

BRANDON

General Hospital

M. Petratz, P. McCunn and Mrs. H. S. Perdue reported on the CNA general meeting as the alumnae association began its activities for the fall and winter. Mrs. Perdue had taken a number of colored pictures and she used these to illustrate her report. The annual meeting is to be held in January and the new officers will be elected then. It was a matter of pride to alumnae members and the hospital to learn that Christina M. MacLeod, a graduate and former director of nursing, had been among those chosen to receive an honorary life membership in the M.A.R.N.

NOVA SCOTIA

TRURO

Colchester County Hospital

Mrs. La Verne MacEachern was appointed superintendent late last fall.

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BIRTHDATE ..... MARITAL STATUS .....

WHERE REGISTERED .....

CLINICAL SERVICE DESIRED .....

POSITION SOUGHT .....

DATE AVAILABLE .....

EDUCATIONAL BACKGROUND

SCHOOL OF NURSING	ADDRESS	DATE OF DIPLOMA OR DEGREE

EXPERIENCE (LIST MOST RECENT POSITION FIRST)

POSITION	HOSPITAL	LOCATION	DATE

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ONTARIO

District 1

Windsor

Grace Hospital

Senior Major Mabel Crolly, a graduate of 1945, was appointed superintendent recently. She replaces Senior Major Gladys Barker who has retired. Over 200 nurses gathered for a party in honor of Major Barker, some of them travelling considerable distances to be on hand. Besides this she was the guest of honor at a tea held by the Ladies' Auxiliary, a luncheon arranged by the medical Advisory Group, a staff reception and an officers' dinner meeting.

Major Crolly, the new superintendent, received her certificate in teaching from the University of Toronto School of Nursing. She was director of nursing services successively at Grace Hospital, St. John's, Grace Hospital, Winnipeg and Grace Hospital, Windsor. Following this, she went to Grace Hospital, Calgary as superintendent where she remained for over three years before being sent to Ottawa's Grace Hospital in the same capacity. She left that city to accept her present appointment.

Hotel Dieu Hospital

The annual bazaar arranged by the alumnae association was held in the Jeanne Mance residence in November. The proceeds are directed mainly to the bursary presented each year. The annual meeting was also held during the same month. In December a Christmas party took the place of the regular alumnae meeting. Members exchanged gifts, enjoyed the program of entertainment, and spent a social hour following it. H. Masse is working at the Ottawa Civic Hospital.

District 4

St. Catharines

General Hospital

The Mack Training School alumnae association has Elizabeth Goold for its president this year. Activities for the fall got underway with a tea and bake sale, the proceeds to be used in celebrating the 85th anniversary of the school in June, 1959. Miss Goold spent a year in Europe recently and has shared her experiences generously with the alumnae members through her colored slides. In December Mr. M. A. Seymour, local lawyer and secretary of the Board of Governors discussed legal aspects of nursing when he attended a regular meeting as guest speaker.

District 5

Toronto

East General Hospital

On October 25, 1958 the class of '57 held their first reunion supper and dance. Everyone had a wonderful time renewing friendships with classmates who, in many cases, had not been seen since student days. R. (McInnis) Robinson, L. (Cunningham) Mason and J. (Saunders) Jones were there, much to the pleasure of the group. The success of this first anniversary was due to the good work of J. (Jackson) Stephany and her assistants, P. Farley, C. McGhee, J. Dent and N. Lamkin.

General Hospital

A. Grenache ('57), M. Smith ('55), J. Gauley ('51), I. Dreschner, J. Finlayson have returned to various staff positions after completing postgraduate university study. Jessie F. Young ('37) has been appointed neurosurgical supervisor in the Central building. M. Dzwin ('54) has returned from New York to take up her new work in the Outpatient Department. V. Lindabury ('53) has been awarded the Business and Professional Women's Club bursary which she will use to study for her B.Sc.N. at the University of Western Ontario. B. (Duval) Varey and M. Hudak ('55) are taking the public health course at the University of Western Ontario. J. Cameron ('48) returned to the city after two years in Khartoum with WHO. M. Booth ('55) was recently appointed clinic nurse at the new Scarbo-

rough Centre of the Children's Aid Society of Metropolitan Toronto.

District 8

Ottawa

Civic Hospital

The annual alumnae bazaar was held early in November of last year in the nurses' residence. H. L. Towlan who received the alumnae bursary-loan for 1958 is studying nursing education at the University of Western Ontario. R. Rogers is on leave of absence to attend Johns Hopkins University, Baltimore. H. Cunningham has been appointed administrative assistant to the director of nursing. W. Lowe is attending the University of Toronto School of Nursing where he is majoring in nursing education. B. (Towns) Haggerman is the supervisor of the Supply Room at Toronto East General Hospital. M. MacKay is on the operating room staff of Oshawa General Hospital. M. Tape and G. Hudson completed study in public health at the University of Western Ontario. S. (Holmes) McDougal is enrolled in the Public Health course at the University of Toronto and M. Wood is attending the University of Western Ontario.

District 12

Kirkland Lake

The fall rally of the district organization of the R.N.A.O. was held at Red Pines Lodge, Lake Kenogami. A buffet supper preceded the business and program sessions. About 50 members and guests attended. Dr. Graham B. Lane, medical officer of health for the Porcupine Health Unit was the guest speaker. His subject, "Radiation," was of keen interest to all. He emphasized chest x-raying in particular and indicated the methods used to reduce radiation hazards to a minimum.

PRINCE EDWARD ISLAND

Charlottetown

The Association of Nurses elected its officers for the current year recently. Those members forming the executive are: Pres., Mrs. V. MacDonald; Past Pres., Ruth I. Ross; Vice Pres., Bernice Rowland, Alice Trainor;; Hon. Treas., Mrs. R. Palmer; Hon. Sec., Frances MacMillan; Exec. Sec.-Registrar, Mrs. Helen L. Bolger; Committee Chairmen: Nursing Education, Sr. M. Monica; Nursing Service, Ida MacKay; Public Relations, Hattie MacLaine; Finance, Mrs. Lois MacDonald; Legislation & Bylaws, Katherine MacLennan.

SASKATCHEWAN

Prince Albert

Holy Family Hospital

The following members of the alumnae association form the executive for the current year: Pres., Mrs. Betty Leland; Vice-pres., Miss McLeod; Sec.-Treas., Olivette Belanger; Councillors, Mmes Bruce, Kasko, Weatherby, Melis; Committees: Program Mrs. H. Redekapp; Membership, Mrs. L. Kent, Mrs. Stene, Mrs. McLean; Publicity, O. Belanger, Misses McLeod, Winnicki.

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Director of Nursing for 180-bed hospital with a school of nursing. Applicant with University Degree &/or postgraduate course preferred. Salary commensurate with experience & qualifications, position available May 1959. Apply: Secretary, Board of Directors, Victoria Union Hospital, Prince Albert, Sask.

Assistant Director of Nursing Education & Surgical Clinical Instructor for 85-student School of Nursing, 200-bed hospital, good personnel policies. Apply Director of Nursing Education, St. Michael's Hospital, Lethbridge, Alberta.

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Supervising Nurse to help plan, equip & operate a new & modern intensive care unit of 21-beds to be opened in the spring of 1959. Position available at once. Salary range between $345 - $410 depending on training & qualifications. Write, wire or call, collect, Director of Nursing, Samuel Merritt Hospital, Oakland, California, OLympic 5-4000.

Assistant Night Supervisor — Head Nurses for Medical & Surgical Wards — **General Duty Nurses** for 450-bed hospital with training school. Excellent personnel policies. Apply to: Director of Nursing, St. Joseph's Hospital, Victoria, British Columbia.

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Registered Nurses (2) for 16-bed hospital 130-mi. west of Winnipeg. Salary $265 gross with increments of $5 every 6-mo. for 4 increases; 8-hr. day; 44-hr. week. 10 statutory holidays; 3-wk. vacation first yr. then 4-wk. Living quarters in hospital; room & board $35 per mo. Apply: Secretary or Matron, Memorial Hospital, Crystal City, Manitoba.

Registered Nurses for modern hospital, comfortable home. Starting salary $250 per mo., maintenance $35 per mo. Apply: Superintendent, Lorne Memorial Medical Nursing Unit, Swan Lake, Manitoba.

Registered Nurses for 206-bed hospital. Basic gross salary $220 plus $5 increase after 6-mo., for 4 years. Included are statutory holidays & sick leave. Positions available in all areas. Apply to Director of Nursing, Hotel-Dieu St. Joseph, Edmunston, N.B.

Registered Nurses for 46-bed hospital in the Annapolis Valley, salary according to R.N.A. suggested policy. Apply: to the Superintendent, Western Kings Memorial Hospital, Berwick, Nova Scotia.

Registered Nurses: for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered Nurses for General Duty modern 18-bed Private Hospital in Iron Mining town, 180-mi. north of Sault Ste. Marie, Ont. Excellent accommodations & personnel policies. Starting salary $255 minimum to $290 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 3-mo. service. Apply Superintendent, Miss O. Keswick, Lady Dunn Hospital, Jamestown, Ontario.

Registered Nurses for general duty in all departments — including operating room, premature & newborn nursery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for Nipigon District Memorial Hospital, Nipigon, Ontario. Starting salary $265 per mo. & additional increment for 3-yr. experience or more. Board & room available at $28.50 per mo., 5½-day wk. 8-hr. duty. 4-wk. vacation after 1-yr. Sick leave, 1 day mo. Apply to: Mrs. G. Gordon, Superintendent, Box 37, Nipigon, Ontario.

Registered Nurses or equivalent European training (3) for 30-bed rural General Hospital. Starting salary $160 per mo. full room & board free, Blue Cross paid, 46-hr. wk. 8-hr. general duty, 1-wk. vacation each quarter (¼), 20-mi. from Ottawa. Skiing, skating, swimming, boating etc. Apply to: Miss Hardy, Matron, Gatineau Memorial Hospital, Wakefield, Que.

Registered Nurses (2) $260 per mo. with increments each yr. 3-wk. vacation & sick leave, residence on grounds. Apply to Secretary, Vanguard Union Hospital, Vanguard, Sask.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts; evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, Calif.

Registered Nurses for new 157-bed General Hospital located in fast growing City of Fremont approximately 1-hr. from heart of San Francisco. Good salary, vacation, sick leave & hospitalization plan. Contact Director of Nursing Services, Washington Township Hospital, P.O. Box 656, Niles, California.

Registered Nurses: Spend your winter in the Sunny Southwest — New Mexico, "The land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics, and Operating Room. Salaries $285-$315, days; $10 differential for evenings & nights; $15 differential, operating room. No shift rotation. Excellent job benefits. Board and room in nurses' residence, $43 per month. Free transportation via 1st Class Air travel to Albuquerque and return in exchange for a 1-yr. employment contract. Write or call collect Mrs. Margaret Nelson, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Ave. S.E. Albuquerque, New Mexico. Phone 3-5611.

Registered Nurses for new 50-bed hospital. Openings on obstetrical wing, evening and night shift. Salary $310. Transportation paid to New Mexico in exchange for 1-year employment contract. Write to Director of Nurses, Carlsbad Memorial Hospital, Carlsbad, New Mexico.

Registered Nurses & Certified Nursing Assistants (immediately) for 73-bed General Hospital on Lake of the Woods. Favorable salaries & personnel policies. Living conditions available. Apply Superintendent, Kenora General Hospital, Kenora, Ontario.

Registered Nurses & Certified Nursing Assistants for new expanding 88-bed hospital in a pleasant progressive town. **General Duty Registered Nurses** start $220, annual increments to $240, **Certified Nursing Assistants** $150, annual increments to $180. 2-wk. shift rotation, bonus for 4-12 & 12-8 shifts. Accumulated sick leave to 60-dy. Only 1-hr. drive to Toronto, to other cities & resort areas. Local swimming pool, artificial ice arena, bowling, etc. Apply: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurse & Licensed Practical Nurse for general floor duty. Gross salary $290 per month for R.N., $200 per month for L.P.N. with $25 deducted for full maintenance. 44-hr. week. For further particulars please apply to John Hiscock, Secretary-Treasurer, Medical Nursing Unit, Baldur, Manitoba.

Registered Nurses & Licensed Practical Nurses for new 33-bed General Hospital with well equipped surgery wing, in new mining town, about 250-mi. east of Port Arthur & northwest of White River, Ontario. Starting salary commensurate with experience & qualifications. Apply: stating qualifications, experience, age, marital status, etc. to Mr. W. Harrison, Room 1715, 44 King Street West, Toronto, Phone EMpire 4-1194, or to Administrator, Manitouwadge General Hospital, Manitouwadge, Ontario, Phone TAylor 6-3251.

Registered Nurses for Operating Room & General Duty Nursing, for 20-bed private hospital. Rotating shifts, averaging 42-hr. per wk. Salary $259 per mo., plus full maintenance. Accommodations provided in nurses' residence — single rooms. Liberal personnel policies, group insurance, pension plan, 1-mo. vacation after 1-yr. service. Sick leave. Excellent recreational facilities. Located in Thunder Bay District of Ontario, on Main C.P.R. Transcontinental line & Trans Canada Highway. Apply: Employment Supervisor, Marathon Corporation of Canada Limited, Marathon, Ontario.

Registered Nurses for Operating Room with operating room postgraduate courses and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $260 per mo.** with semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Laboratory Technician (Male or Female) will consider recent graduate who has not taken the Registry. Good personnel policies; salary open. Write or phone: Administrator, Sidney A. Sumby Hospital, River Rouge 18, Michigan.

Surgical Registered Nurses, Staff Registered Nurses for 240-bed General Hospital. 40-hr. wk. 15 working days; paid vacation; 7 paid holidays; sick leave. Surgery starting base pay $338 stand by & call back time extra. **Staff R.N.** starting pay $322 monthly; regular pay increases; P.M. & night differential $10. Apply: Yolo General Hospital, P.O. Box 210, Woodland, California.

Registered General Duty Nurses (2) Starting salary $260 gross, personnel policy upon request, living in residence. Apply, Matron, Myrnam Municipal Hospital, Myrnam, Alta.

Registered General Duty Nurses. Salary: $230 per mo. 40-hr. wk. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Registered Nurses for General Duty good salary with full maintenance & laundry. Excellent accommodation in nurses' residence, single rooms. Good working conditions. For application please write to Superintendent of Nurses, Mount Sinai Sanatorium, Ste. Agathe des Monts, Quebec.

Registered General Duty Nurses for **118-bed General Hospital** along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $340 for days, $370 for evenings, $360 for nights. 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Registered Nurses for 100-bed general hospital in town of 6000 on the shore of Lake Huron. Good personnel policies, residence accommodation available. Apply: Superintendent, Alexandra Marine & General Hospital, Goderich, Ontario.

General Duty Registered Nurses & Operating Room Nurse (1) for new 56-bed hospital on Georgian Bay. Attractive residence. Gross salary $225 per mo. for general duty, 44-hr. wk. All statutory holidays, 12-dy. sick leave, 3-wk. vacation after 1-yr. Apply to Director of Nursing, Meaford General Hospital, Meaford, Ontario.

Baker Memorial Sanatorium, Calgary, Alberta, offers to Graduate Nurses a 6-mo. postgraduate course in Tuberculosis. Salary: $3,480 to $4,080 per annum. Openings also available for **General Duty Nurses.** Residence with board, if desired, $30 per mo. Excellent holiday, sick leave & pension benefits. Apply to: Superintendent of Nurses.

General Duty Nurses (3) for 64-bed hospital, salary $250 less $35 for room & board, $5 increase after 6-mo. for 6 increases, 44-hr. wk. 4-wk. paid vacation after 1-yr. service. Statutory holidays, 1½-dy. sick leave per mo. Transportation up to $50 refunded after 1-yr. service. Apply: Sister Superior, Providence Hospital, High Prairie, Alberta.

General Duty Nurses for R. W. Large Memorial Hospital United Church of Canada at Bella Bella 300-mi., north of Vancouver on B.C. Coast. Transportation refunded after 1-yr., Apply to, Matron, R. W. Large Memorial Hospital, Bella Bella, British Columbia.

General Duty Nurses for a new 26-bed hospital in the Fraser Valley, 100-mi. from Vancouver. Good personnel policies, accommodation available in a new residence. Apply Director of Nurses, Fraser Canyon Hospital, Hope, British Columbia.

General Duty Nurses for new 85-bed hospital. Good salary & generous personnel policies. Apply to the Director of Nursing, Portage Hospital Dist. #18, Portage la Prairie, Manitoba.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $235 per mo. with annual increments. Good personnel policies with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $250 per mo. 40-hr. wk. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

General Duty Nurses for modern 42-bed hospital, starting salary, new graduates $255 with two (2) yr. experience $270 provided Ontario registration is obtained; these rates to be revised October 1st. Ontario registration required for maximum salary. Annual increments, 6% bonus for evening & night shifts. 44-hr. wk. with 8 statutory holidays, annual vacation 21 days first yr. 28-dy. thereafter, monthly sick time allowance. Good living accommodations available. Apply to: Nursing Supervisor, Sioux Lookout General Hospital, Sioux Lookout, Ontario.

General Duty Nurses for 163-bed Tuberculosis Sanatorium. Good salary & personnel policies. Residence accommodation available. Please apply Director of Nurses, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

General Duty Nurses (3) for new 11-bed hospital, $260 per mo., benefits according to S.R.N.A. Apply with references to Matron, St. Walburg Union Hospital, St. Walburg, Sask.

General Duty Nurses (English speaking) for 466-bed hospital. Nurses' residence available. Salary: $315, California registered — $285, Canadian registered. $22.50 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, Calif.

General Duty Nurses for 600-bed teaching hospital in central California. Inservice educational program; 40-hr. wk., 11-holidays yearly, retirement & sick leave plan. P.M. & night shift differential. $337 per-mo. to start. Write Personnel Director, 732 East Main St., Stockton, California.

General Duty Nurses & Operating Room Nurses for 434-bed hospital; 40-hr. wk. Statutory holidays. Salary $250-$312. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Attention! General Duty & Surgery Nurses for 400-bed County Hospital located 2-hr. drive from San Francisco, ocean beaches, & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. paid vacation, 11 paid holidays, paid sick leave, retirement plan & social security. Accommodations in Nurses' Home, meals at reasonable rates, uniforms laundered without charge. General Duty, $333 mo. start plus shift & service differentials. Surgery $382-$460 mo. comp. time if on call. Must be eligible for Calif. Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted as a vacation land in summer with 7-mi. of sand beach, along with great skiing on the Blue Mountains in winter. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Registered Nurses for general duty, obstetrics & operating room, starting salary $320 per mo., $10 differential paid for afternoon & night shifts, also for obstetrics, nursery & operating room; 40-hr. wk.; liberal vacation policy; sick leave; holidays; paid health insurance. Moving into new hospital building January, 1959. Apply: Personnel Director, Fresno Community Hospital, Fresno, California.

General Duty Nurses & Certified Nursing Assistants: living-in accommodation, comparable salaries, 44-hr. week. Apply Memorial Hospital, Durham, Ontario.

General Duty Graduate Nurses for an active 76-bed hospital near Calgary & Banff. $250 gross salary, $260 for Alberta registered, good personnel policy. Apply to Matron, Brooks Municipal Hospital, Brooks, Alberta.

Graduate Nurses for 70-bed General Hospital. Salary $260-$280; 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 yr. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for new 140-bed hospital. 1. Charge nurse for Central Supply, to open and organize dept. 2. Head nurse for Pediatric dept. 3. Head nurse for men's Medical and Surgical 24-bed dept. 4. Operating Room nurse (1) 5. General duty nurses. Positions 1 to 4 all to have postgraduate courses or equivalent in experience. Salaries and personnel policies in accordance with R.N.A.B.C. Positions open August to November 1. Apply, Director of Nursing, General Hospital, Chilliwack, B.C.

Graduate Nurses: for new 63-bed hospital, 30 miles from Vancouver in the Fraser Valley. For Salary rates & Personnel policies. Apply: Director of Nursing, Maple Ridge Hospital, Apply, Director of Nursing, General Hospital, Chilliwack, British Columbia.

Graduate Nurses for 37-bed hospital, salary $250 per mo. with annual increments — 28-dy. annual vacation, cumulative sick leave — $50 monthly; board, lodging, laundry. New 50-bed hospital to be erected 1959. Apply: Administrator, Terrace & District Hospital, Box 1297, Terrace, British Columbia.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $315 per mo. starting salary. $15 per mo. merit increases at 12, 24 & 36 mo. 40-hr. wk. 2-wk. paid vacation, paid sick leave, 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

Staff Nurses for 250-bed General Hospital, located on the Bay of Quinte; approved School of Nursing; planned In-Service education program; desirable personnel policies. For further information, Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, Liberal personnel policies. Salary $320-$360. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Nurses: Relocate to Sacramento, Calif. Sutter Community Hospitals, 440-beds, offer $340 per mo. starting salary, $25 per mo. for p.m. & night differential. Tenure salary increase plan, 40-hr. wk., Social Security & liberal employee benefit program. Write to Personnel Office.

Pediatric Nurses for 100-bed Pediatric teaching hospital; air conditioned. Good personnel policies. Base salary-rotation $290 per mo. Evenings or night $304 per mo. Apply: Director of Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Operating Room & General Duty Nurses for expanding active 350-bed General Hospital. 8-hr. day, 5-dy. wk. with 3-wk. vacation for 1st & 2nd year; thereafter, 4-wk. Apply: Director of Nursing, Port Arthur General Hospital, Port Arthur, Ontario.

Operating Room Nurse (P.M.) for 147-bed General Hospital located in a beautiful residential surburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40 hr. wk. Salary: $365 for days, $395 for evenings. Other employee benefits. Contact the Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Public Health Nurses: required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Public Health Nurses for generalized program, rural & urban. Salary range $3,300-$4,300, annual increment $200, pension plan, Blue Cross, 4-wk. vacation, cumulative sick leave. Apply: J. R. Mayers, M.D., D.P.H., Director, Norfolk County Health Unit, 58 Peel Street, Simcoe, Ontario.

Nurses for floor duty in 54-bed General Hospital. 5-dy. wk. with sick leave & vacation. State Nurses Association pay scale. Write or phone McMinnville Hospital, Inc., McMinnville, Oregon.

Public Health Nurse (Qualified) minimum salary $3,200; allowance for experience. $150 annual increments; 5-day week; 4wk. vacation; sick leave credits; Blue Cross, pension plan, car allowance. Financial assistance towards purchase of car. Apply to Mr. A. F. Stewart, Secretary-Treas., Wentworth County Health Unit, Court House, Hamilton, Ontario.

Operating Room Supervisor, Operating Room General Duty Nurse for 110-bed modern hospital. Excellent personnel policies. Apply: Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick.

Operating Room Nurse for 205-bed new hospital in Georgian Bay Area. Live in if desired. Apply: stating experience, to Director of Nursing, General & Marine Hospital, Owen Sound, Ontario.

Operating Room Supervisor (Immediately) for 86-bed hospital. Good salary, employee benefits & statutory holidays, living accommodation available in residence. Locate in Collingwood & enjoy many winter sports along with excellent skiing in the Blue Mountains. Apply, Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Graduate Nurses for Eastern Townships Hospital. 28 days annual holiday. Complete maintenance. Salary commensurate with experience. Apply, E. Decker, Brome-Missisquoi-Perkins Hospital, Sweetsburg, Quebec.

General Staff Nurses for fully accredited private teaching hospital, located on Lake Michigan just north of Chicago. 5-day, 40-hr. wk. Salary range $337.35 to $363.30. Shift bonus: $26 afternoons & $17 nights. Progressive personnel policies. Please indicate type of service preferred. Apply: Director of Nursing, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

Registered Nurses: staff positions; starting salary $355 per month. Competent nurses who have had six months experience in accredited hospitals may qualify as Assistant Head Nurses, $395. Differential for evening and night duty, full Civil Service benefits, 40-hour week, paid overtime. Choice of services. Current openings are on Medicine, Orthopedics, Communicable Diseases, G.U., or Neurology. R.N.s must speak and write English. For full details, write: Mrs. Betty Hartwig, R.N., Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California.

Staff Nurses (3 immediately) for 18-bed Community Hospital in scenic setting in the heart of the Canadian Rockies. Starting salary $250 per mo. Fulll maintenance available in modern nurses' residence. For full particulars write: C. F. Collins, Secretary, General Hospital, Golden, British Columbia.

Nursing Supervisor for community owned 18-bed General Hospital. Full maintenance $48 per mo., in new modern nurses' residence on hospital grounds. Scenic location, in Rocky Mountains west of Calgary, Alberta on Trans Canada Highway. For full particulars write: C. F. Collins, Secretary, General Hospital, Golden, British Columbia.

Matron (Immediately) for 5-bed medical nursing unit. Salary $275 less maintenance, 44-hr. wk., excellent staff accommodation. 80-mi. west of Winnipeg on No. 1 highway, good train & bus service. For further particulars, apply to Mrs. M. C. Roberts, Sec'y. of North Norfolk-MacGregor Medical Nursing Unit, MacGregor, Manitoba.

General Duty Graduate Nurses (2). Salary $260 per mo. with annual increments of $10 per mo. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

PUBLIC HEALTH NURSES GRADE (1)

British Columbia Civil Service

Positions available for qualified Public Health Nurses in various centres in B.C.

Salary: $290 rising to $345 per mo., car provided. An opportunity for interesting & challenging professional service in this beautiful & fast developing province. Competition No.: 58:511.

For information & application forms, write

THE DIRECTOR,
PUBLIC HEALTH NURSING, DEPT. OF HEALTH, VICTORIA, B.C. or
THE CHAIRMAN,
B.C. CIVIL SERVICE COMMISSION, 544 MICHIGAN STREET, VICTORIA, B.C.

Dietitian for 90-bed accredited Hospital. Help maintain patients contact; salary open, excellent benefits. Write or phone: Administrator, Sidney A. Sumby Hospital, River Rouge 18, Michigan.

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

General Duty Nurses for small active hospital. Salary $250 for unregistered. $260 registered with yearly increments. Nurses' Home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

Director of Nursing for approved J.C.A.H. 108-bed hospital planning a 100-bed addition. No school of nursing at present. Degree in nursing administration preferred but not essential. Successful experience in nursing education would be an advantage. Salary open. Personnel policies include 40-hr. wk. pension plan, sick leave, 4-wk. vacation after 1-year of service, 8-statutory holidays. Apply: Administrator, Civic Hospital, North Bay, Ontario.

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KINGSTON, ONTARIO

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Director of Nursing Education (1) by July, 1959. Qualifications — Bachelor of Science in Nursing Degree plus 3-5 years experience.

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1. Qualified Clinical Instructresses. Maternity (1) Medicine (1) and Surgery (1).
2. General Duty Nurses (12)
3. Practical Nurses (6)

Salary commensurate with preparation & experience.

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required

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Salary $275 - $325

Good personnel policies.

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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $340-$350 for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities.

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For a school of 90-students, organized independently of Nursing Services.

The school program follows the pattern of 2-years of nursing education plus 1-year of internship.

Requirements: Degree & experience in the administration of a nursing education program.

Apply to: R. Buckner, Administrator,

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Superintendent of Nurses — required March 1st and immediately

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General Hospital: General Duty Nurses
Maternity Nurses
Nursing Assistants

Tuberculosis Hospital: General Duty Nurses
Nursing Assistants

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London, W.C.1
and
MAIDA VALE HOSPITAL
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One year courses are open to Nurses on the General Register with good educational background.

3 mo. full time instruction in the school under guidance of the Sister Tutor assisted by a teaching staff of senior neurologists & neuro-surgeons.

8-mo. clinical experience, 1 mo. vacation.

Certificate & badge of the hospital awarded to successful students. Staff nurses' salary paid throughout the year. This work has a special appeal to nurses interested in research & the humanitarian aspect of nursing.

For further particulars apply to the Matron,
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PSYCHIATRIC NURSING INSTRUCTRESSES

required by the

SASK. DEPT. OF PUBLIC HEALTH

SALARY: $375 per month for those with postgraduate training; $359 for those without this training.

REQUIREMENTS: R.P.N. and/or Reg. N., preferably both registrations and postgraduate training in nursing teaching and supervision. Consideration will be given to those who have registration in either field of nursing but who do not have the required postgraduate training but are interested in provisional appointments pending formal training for which financial assistance may be provided.

DUTIES: Appointees will serve as instructresses in a three year, 600 hour training program for student psychiatric nurses. They will give lectures, lead seminars and give practical demonstrations designed to co-ordinate classroom theory and work on the wards.

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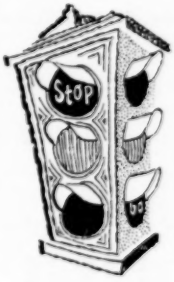

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For new 85-bed General Hospital. Situated in a city of 10,000 population with (2) R.C.A.F. Bases and has many recreational facilities.

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A Number of Public Health Nurses to work in rural Health Units

Applicants should be nurses registered in Manitoba preferably with post-graduate training in Public Health Nursing or willingness after one year's employment to take postgraduate training in Public Health.

Salary schedule with R. N. only $3,120-$4,020 per annum.

With R. N. plus certificate in Public Health Nursing $3,480-$4,380 per annum.

Full Civil Service benefits, including liberal sick leave with pay, three weeks vacation with pay and pension privileges.

Apply stating training, experience and age to:

THE DIRECTOR,
PUBLIC HEALTH NURSING SERVICES,
320 SHERBROOK STREET, WINNIPEG, MAN.

GENERAL HOSPITAL

ST. JOHN'S, NEWFOUNDLAND CANADA

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Applications are invited for an Operating Room Supervisor to organize and administer a new 12 room operating theatre and a recovery room.

Qualifications must include postgraduate study in operating room administration and experience of not less than two years in operating room supervision.

Must be eligible for registration in Newfoundland.

Liberal sick leave and annual leave policies. Salary open.

Would be prepared to consider a 1 or 2-yr. contract. Transportation to Newfoundland will be paid on the basis of a minimum of one year's service.

Position will be available in the Spring of 1959.

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ST. JOHN'S, NEWFOUNDLAND, CANADA

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(1) Public Health Nursing Supervisors: up to $5,220 depending upon qualifications and location.

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(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

• Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.

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(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

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